

Medicaid Purchase Plan Evaluation 2011 Annual Report

for

Office of Independence and Employment,
Department of Health Services

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I. Executive Summary

This annual report summarizes the Medical Assistance Purchase Plan (MAPP) during calendar year 2011 and provides a retrospective analysis of MAPP since it began in 1999. This report was conducted by HRG Consulting, Inc., under a contract with the Department of Health Services (DHS), Division of Long-Term Care, Office of Independence and Employment (OIE).

MAPP allows individuals with disabilities who are working and whose family income is below 250% of the federal poverty level to buy into Medicaid. MAPP's purpose is to provide people with disabilities an opportunity to overcome key barriers to employment while maintaining access to health care services. In surveys of MAPP participants, health care has been cited as the essential employment support in enabling people with disabilities to work. Specifically, the three goals of the program are to:

- Encourage people with disabilities to earn more income
- Offer an effective, efficient and equitable program that allows people with significant disabilities the opportunity to work without jeopardizing their health care coverage
- Allow people with disabilities to save and make purchases toward their independence, similar to opportunities currently available to the majority of the workforce

This report is focused on providing an overview of program characteristics – enrollment trends, income trends, and demographic information – as well as a thorough look back on the challenges encountered in the first twelve years of MAPP.

Since the program's inception, MAPP enrollment has grown steadily. As of September 2011, just over 36,000 individuals have been enrolled in the program at one point. September 2011 active enrollment was just over 20,000. As of December 2010, participants had earned income ranging from \$0 to \$5,395 per month with an average of \$139 and a median of \$21.¹ Average earnings has continued to decline since the programs inception. Earnings trends are presented in detail in Section III.

MAPP participants whose adjusted gross individual income exceeds 150% of the federal poverty level for their family size (FPL) are subject to a premium². The majority of MAPP participants do not pay a premium to participate in MAPP. According to Medicaid eligibility data, the percentage of MAPP participants assessed a premium dropped from 13% in 2002 to about 4% in 2011. Still, despite this decrease in percentage of participants who pay a premium, as the program continues to grow, the total amount of assessed premiums continues to increase. During the 2011 calendar year, premiums assessed totaled \$2.4 million, up from \$2.2 million in 2009.

Through December 2011, just over \$16 million in MAPP premium payments had been assessed since the program's inception, helping to offset program cost. Of those who paid a premium, the

¹ These figures include 18,154 participants with income information available through the CARES system. Earned income figures represent monthly earned income reported by participants through CARES in December 2010.

² 150% of FPL in 2011 was \$16,335 (\$1,361 monthly)

average premium payment throughout 2011 was about \$240. The largest group of those assessed a premium continues to be the \$25 group comprising about one-fifth of the total premium-paying group.

In addition to program demographics and participant characteristics for the past year, this report also includes a broader look at participant and program trends over the last twelve years. This report takes a look back on program challenges throughout the years. From early challenges, such as a manual, paper-based eligibility determination system to more chronic challenges such as the premium structure, program-defining issues and responses are discussed within the context of the three aforementioned goals of MAPP.

MAPP has provided more individuals than originally expected with health care coverage along with the opportunity to work. However, the coexistence of these two foundations has not been harmonious; fear of losing health care benefits has been notoriously difficult to allay, and MAPP participants have been earning at lower and lower rates *on average* since the program began. Despite these challenges, MAPP continues to provide an important health care benefit to thousands of people with disabilities while encouraging them to work.

II. Background and program overview

Prior to the Medical Assistance Purchase Plan (MAPP), working individuals with disabilities faced substantial barriers to working, increasing income and accumulating wealth through saving a portion of income. Wisconsin, like most states, uses the Supplemental Security Income (SSI) standard for determining eligibility for some Medicaid programs. That standard basically equates a finding of “disabled” with an inability to work substantially. The difficulty in obtaining a finding of disability renders those found eligible reluctant to attempt work for fear of having provided evidence that employment capacity has been recovered.

Further, the financial need basis of Medicaid limited earning and saving, creating an environment where workers with disabilities feared losing health care coverage if they exceeded the relatively low wage and asset limits of traditional programs.

The Balanced Budget Act of 1997 (BBA) gave states the option of providing Medicaid coverage to working individuals with disabilities who, because of their earnings and savings, could not otherwise qualify for Medicaid. Section 4733 of the BBA allowed states to provide Medicaid coverage to these individuals by creating a new categorically needy eligibility group. In 1999 Wisconsin’s Act 9, under the authority provided by the BBA, created the Medical Assistance Purchase Plan or MAPP, which was subsequently implemented on March 15, 2000.

Program Goals

The goals of MAPP were to provide people with disabilities an opportunity to overcome key barriers to employment and foster economic and social independence. The three originally stated goals of the program were to

- Encourage people with disabilities to earn more income
- Offer an effective, efficient and equitable program to allow people with significant disabilities the opportunity to work without jeopardizing their health care coverage; and
- Allow people with disabilities to save and make purchases toward their independence, similar to opportunities currently available to the majority of the workforce

Eligibility Criteria

To be eligible for MAPP, an individual must be a Wisconsin resident and at least 18 years of age. The person must possess a disability determination from the Department of Health Services (DHS) Disability Determination Bureau (DDB). Participants must also be working³ or enrolled in a Health and Employment Counseling Program (HEC) and have countable assets under \$15,000⁴.

³ Employment includes work for monetary compensation, or in kind compensation – for example, performing babysitting services in exchange for groceries or a discount on rent.

⁴ Countable assets include items such as cash savings, life insurance policies, and stocks and bonds, but do not include an individual’s home or vehicle.

Program Features

The MAPP program includes a number of features designed to foster independence:

Health Care Coverage: The MAPP program offers health care coverage to working individuals with disabilities. While family coverage is not available, if more than one family member has a disability, each person with a disability may be eligible for the program if he/she meets all of the eligibility requirements.

Independence Accounts: Once enrolled in MAPP, participants can establish Independence Accounts (IAs), which are intended to foster savings for items that increase personal and financial independence. Traditional, non-MAPP Wisconsin Medicaid allows assets up to \$2,000 for an individual or \$3,000 for a family annually. By establishing an IA, MAPP participants can save earnings above those amounts as well as the \$15,000 countable asset limit established for entrance to the program. Total annual deposits to IAs cannot exceed 50% of gross earned income each year. A key feature of MAPP is that earnings above substantial gainful activity (SGA, a monthly net earning threshold set annually by the Social Security Administration or SSA) level do not automatically disqualify an individual from MAPP eligibility.

Flexible Eligibility: All Medicaid buy-in programs require participants to be employed as an element of eligibility. Nevertheless, MAPP provides two work exemption provisions: one for individuals meeting the disability standard who are not yet working but have a certified plan for obtaining employment and one for workers who are episodically too sick to work. The former group can gain eligibility by submission of the VR plan or by developing one of their own. The latter group includes participants who were enrolled in MAPP for at least six months prior to needing the work exemption. The exemption can last up to six months and is limited to two exemptions every three years.

Premium Requirement: MAPP participants are eligible for the same health care services available to any other group through Wisconsin's Medicaid program. These services are available at no cost to individuals whose total income is less than 150% of the federal poverty level (FPL)⁵. Individuals with a total income that meets or exceeds 150% of the FPL are required to pay a premium to participate in the program.

Monthly premiums for MAPP are based on an individual's monthly income and family size. Spousal or other family member income is not counted in the premium calculation, but those individuals are counted when determining family size. The amount of a MAPP recipient's premium is based on his/her adjusted earned and unearned income. *Unearned income* includes Social Security benefits, disability benefits and pensions. *Adjusted unearned income* equals total unearned income less certain deductions. *Earned income* is income from paid or self-employment. *Adjusted earned income* equals gross earned income before taxes and any remaining income deductions from unearned income⁶.

⁵ 150% of FPL in 2011 was \$16,335 (\$1,361 monthly)

⁶ Deductions include: Standard living allowance (\$777 per month for calendar year 2011); MAPP specific impairment-related work expenses (IRWEs), such as transportation to employment

A MAPP premium is the sum of one's adjusted unearned income and 3% of one's earned income. In the following example, the applicant receives a \$900 monthly Social Security Disability Insurance (SSDI) payment and earns \$800/per month. He spends \$50 a month on cab fare to work and designates this as an IRWE. The applicant also has \$10 in medical payments per month and designates that as an MRE.

Calculation of Monthly Premium

Monthly Unearned Income =	\$ 900
Less Standard Living Allowance	\$ 777
Less impairment related expenses	\$ 50
Less medical/remedial expenses	<u>\$ 10</u>
<i>Adjusted Unearned Income</i>	\$ 63
Monthly Earned Income =	\$ 800
Less Remaining Deductions	<u>\$ 0</u>
<i>Adjusted Earned Income</i>	\$ 800
	x .03
	\$ 24
	<u>+ 63</u>
Premium Income	\$ 87
Premium Amount⁷	\$ 75

It is also important to note that MAPP as a work support does not exist in isolation. It is one part in a complex network of federal and state programs, each with its own set of eligibility rules and policy features. Most MAPP participants receive a Social Security Disability (SSDI) or SSI cash benefit, which means they are also receiving (or waiting for) Medicare or Medicaid coverage, respectively. Since each program has its own set of rules, which not infrequently conflict or work at cross-purposes with each other, participation in several programs is complex. An increase in income encouraged and supported by one program may render the participant ineligible for one or more other entitlements.

While this report focuses on MAPP – its rules, benefits, and outcomes – it is essential to realize that there are other programs and services tied to these rules, benefits and outcomes. This makes the examination of participants' behavior, a primary interest in every annual evaluation, more

Medical; and remedial expenses (MREs), such as attendant care

⁷ Premium income between \$75 and \$100 results in a premium of \$75. A premium schedule is included as Attachment B in Section VI Appendix.

complex, as there are typically additional considerations involving programs only tangentially related to MAPP.

Evaluation Contract

Under a contract with the DHS, APS Healthcare (dba Innovative Resource Group) initiated an ongoing evaluation of MAPP starting in 2000. The last two years this work has been the responsibility of HRG Consulting, Inc. These annual evaluations have focused on policy, processes specific to MAPP from implementation through on-going eligibility determination, and employment outcomes.

III. Program Demographics and Participant Characteristics

Data Sources

Data used in this section come from two main sources: the Member Universe from Wisconsin's Medicaid Data Warehouse and data from the Community Aids Reporting System (CARES). *Enrollment* trends reported herein are based on data through September 2011. Data from the final quarter of 2011 were not complete at the time of this report preparation. *Participant characteristics* are based on CARES data from December 2010, the most recent month such data is available.

*Enrollment Trends*⁸

As part of the ongoing MAPP evaluation, quarterly reports to DHS staff provided regular updates on enrollment trends and participant characteristics, both of which underwent changes over the course of MAPP's first twelve years. Table 1 shows a truncated version of the original table from which this section's enrollment charts are derived. For a full table of enrollment data from MAPP's first twelve years, please see Attachment A in Section VI Appendix.

As of September 2011, there were 20,144 individuals enrolled in MAPP. Table 1 provides additional information regarding these individuals, including those with previous eligibility in other Medicaid programs, those who have since disenrolled from MAPP, and the number of disenrollees who have since become eligible for a different Medicaid program. These particular calculations provide some insight into the issue of Medicaid "churn" (i.e., participants moving between different Medicaid programs) and underscore the likelihood that if Medicaid eligible individuals were not in MAPP, there is a strong possibility they would be enrolled in some other Medicaid program.

Table 1

Month/ Year	New MAPP Enrollees	# With Elig. Prior Month	% With Elig. Prior Month	# With Any Prior Elig.	% With Any Prior Elig.	# With Post MAPP Elig.	# MAPP Disenroll	# MAPP Net Enroll
Jan - 09	408	156	38.2%	366	89.7%	274	173	235
Feb - 09	274	85	31.0%	248	90.5%	188	197	77
Mar - 09	329	122	37.1%	284	86.3%	212	205	124
Apr - 09	341	125	36.7%	310	90.9%	221	218	123
May - 09	308	118	38.3%	272	88.3%	198	198	110
Jun - 09	339	114	33.6%	304	89.7%	218	205	134
July 09	324	127	39.2%	287	88.6%	192	223	101
Aug - 09	340	122	35.9%	295	86.8%	202	225	115
Sep - 09	367	116	31.6%	315	85.8%	200	225	142
Oct - 09	389	152	39.1%	336	86.4%	182	194	195
Nov - 09	339	119	35.1%	292	86.1%	157	221	118
Dec - 09	357	136	38.1%	319	89.4%	172	242	115
Jan-10	408	128	31.4%	362	88.7%	288	181	227

⁸ Source: Calculations for enrollment analyses derived from the Member Universe, Wisconsin Medicaid Data Warehouse.

Month/ Year	New MAPP Enrollees	# With Elig. Prior Month	% With Elig. Prior Month	# With Any Prior Elig.	% With Any Prior Elig.	# With Post MAPP Elig.	# MAPP Disenroll	# MAPP Net Enroll
Feb-10	355	124	34.9%	320	90.1%	251	204	151
Mar-10	429	159	37.1%	366	85.3%	276	203	226
Apr-10	383	112	29.2%	336	87.7%	266	203	180
May-10	379	148	39.1%	330	87.1%	237	258	121
Jun-10	371	149	40.2%	327	88.1%	240	217	154
Jul-10	410	178	43.4%	358	87.3%	267	206	204
Aug-10	381	133	34.9%	336	88.2%	229	281	100
Sep-10	406	145	35.7%	351	86.5%	225	243	163
Oct-10	415	170	41.0%	371	89.4%	239	265	150
Nov-10	381	123	32.3%	330	86.6%	222	267	114
Dec-10	370	145	39.2%	316	85.4%	178	261	109
Jan-11	439	144	32.8%	392	89.3%	203	263	176
Feb-11	392	148	37.8%	354	90.3%	197	288	104
Mar-11	415	142	34.2%	369	88.9%	182	262	153
Apr-11	365	114	31.2%	321	87.9%	157	277	88
May-11	340	139	40.9%	294	86.5%	145	329	11
Jun-11	415	136	32.8%	367	88.4%	156	334	81
Jul-11	369	163	44.2%	333	90.2%	122	320	49
Aug-11	348	122	35.1%	301	86.5%	113	376	-28
Sep-11	360	123	34.2%	316	87.8%	86	339	21
Sums	36,415	19,321	53.1%	32,050	88.0%	27,411	16,272	20,144

The following describes the data contained in each column of Table 1:

New MAPP Enrollees

This column indicates the number of individuals who enrolled in the Medicaid Purchase Plan (MAPP) each month since the inception of the program. These totals do not include individuals who have been previously enrolled, then disenrolled, and are enrolling again. Anyone included in this column is a first-time enrollee. As of September 2011, just over 36,000 individuals were ever enrolled in MAPP.

Number with Eligibility Prior Months

Enrollees included in this column have been enrolled in Medicaid under a non-MAPP medical status code within the 31 days prior to their first-time MAPP enrollment month. This column highlights the number of first-time MAPP enrollees who have left traditional Medicaid to enroll in MAPP. Of the 36,415 individuals ever enrolled in MAPP, 53% (19,321) of them were enrolled in another Medicaid program the month immediately prior to enrolling in MAPP.

Number with Any Prior Eligibility

Enrollees included in this column have been enrolled in Medicaid under a non-MAPP medical status code at any time prior to their first-time MAPP enrollment month. This column is similar to the “Eligibility Prior Month” column except that there is no 31-day time constraint. While just over 19,000 individuals were enrolled in another Medicaid program *immediately* before entering MAPP, this number increases substantially once the 31-day time constraint is removed. About 88% (32,050) of those ever enrolled in MAPP at some point were in a different Medicaid program prior to entering MAPP. This percentage (88%) has remained steady in the last few years of the evaluation, allowing

for the interpretation that nearly 9 out of 10 MAPP participants were enrolled in another Medicaid program at some point before joining MAPP. The reason(s) for the switch have not been well documented.

Number with Post MAPP Eligibility

This column reflects the number of MAPP enrollees who have a non-MAPP eligibility segment any time after their first-time MAPP eligibility. Of the 36,415 individuals ever enrolled in MAPP, about 75% (27,411) left MAPP at some point to join a different Medicaid program. Unlike the steady percentage of MAPP participants drawn from other Medicaid programs, the percentage of MAPP participants who at some point transfer to a different Medicaid program has increased over the last few years. Two years ago, only 70% of the total number of MAPP participants ever enrolled had a non-MAPP eligibility segment following MAPP enrollment; this percentage has increased to 75%. Although the reasons for this increase have not been investigated, it is possible that the harsh economy impacted participants' employment and forced them to leave MAPP, which technically requires that participants be employed (for pay, for in-kind remuneration through the Health and Employment Counseling program, or in one of the grace periods triggered by long-term illness).

MAPP Disenrollments

This column reflects the number of enrollees who have disenrolled from the MAPP program. First-time enrollees and enrollees who have enrolled multiple times are counted; this is a comprehensive number of all the enrollees leaving the program in a given month. New eligibility segments beginning directly after the end date of a previous eligibility segment are originally counted as disenrollments, and later adjusted for continuous enrollment. The number of disenrollments fluctuates from month to month but has been at least 200 per month over the last year, climbing to over 300 for the latter part of 2011. As overall enrollment in MAPP grows, it is to be expected that the absolute number of disenrollees increases.

MAPP Net New Enrollees

This column indicates the difference between the number of enrollees who have disenrolled, first-time and multiple occasion enrollees, versus the number of new enrollees. Recent net new enrollment has hovered somewhere between 100 and 200 individuals each month, with recent months falling below 100.

New Enrollment and Disenrollment by Quarter⁹

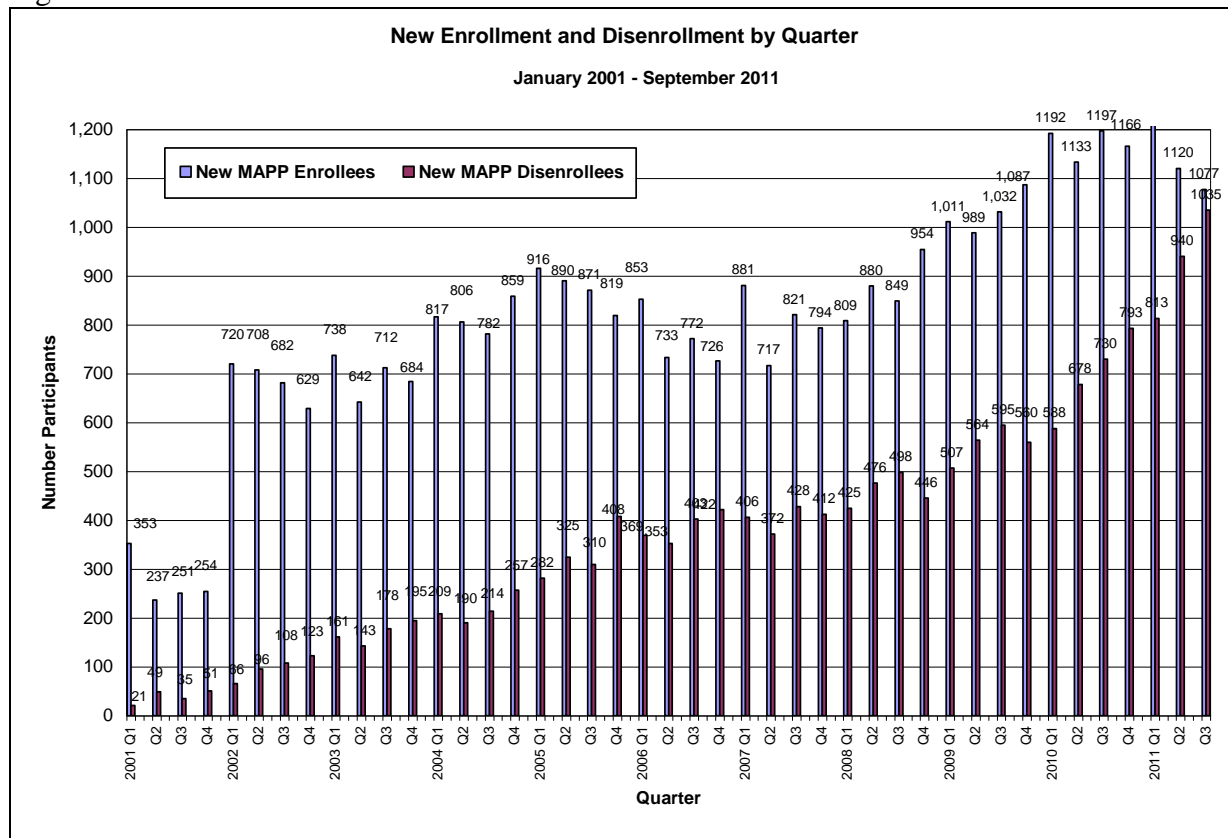
Figure 1 illustrates the final two columns of the Eligibility Trends table, presenting data on a quarterly basis.

The bars on the chart represent the number of individuals who have enrolled in the program and those who have disenrolled.

⁹ Source: Calculations for enrollment analyses derived from the Member Universe, Wisconsin Medicaid Data Warehouse.

New enrollment (gross) has remained above 1,000 per quarter since 2009. As might be expected as a program matures and grows in size, the number of disenrollees has continued to rise throughout MAPP's history. The chart illustrates that the number of quarterly disenrollments appears to have increased at a steeper rate recently than in prior years, which corroborates the increased percentage of MAPP participants leaving MAPP for other Medicaid programs.

Figure 1



Net Growth by Quarter¹⁰

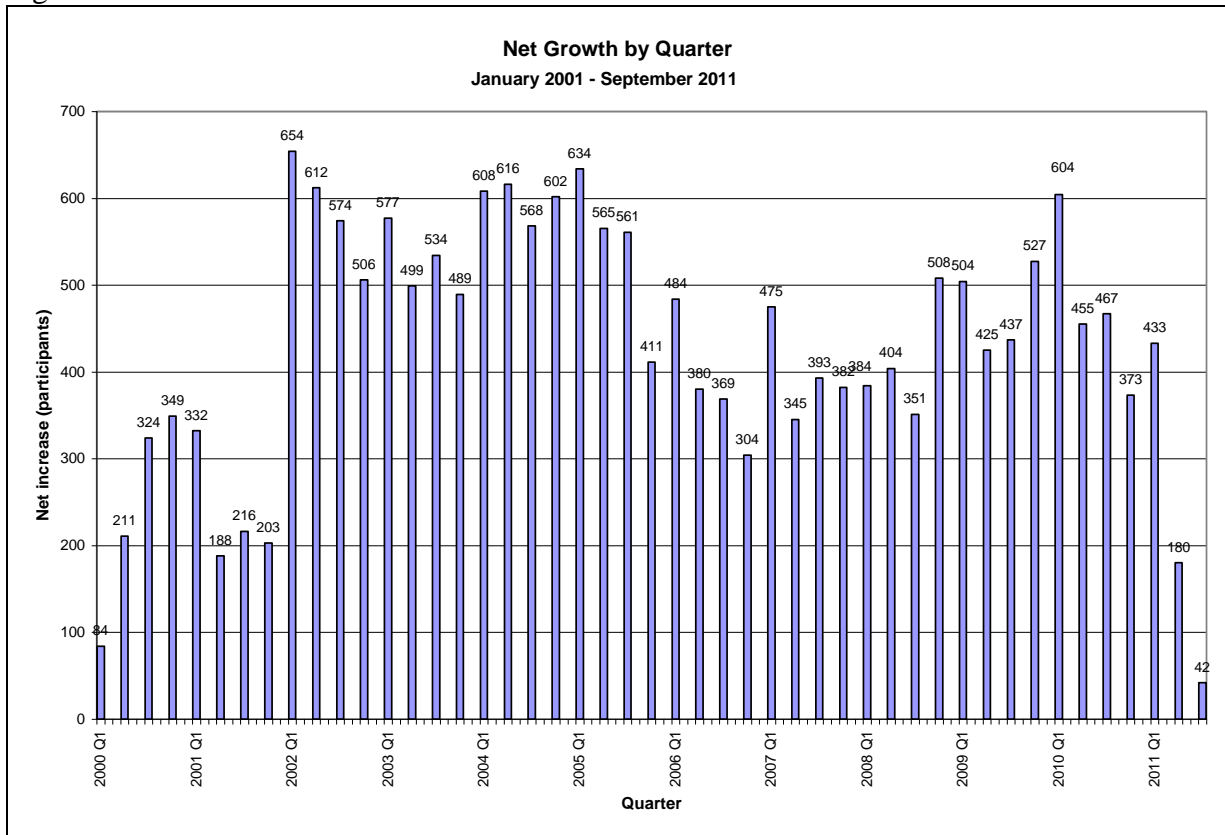
Figure 2 below isolates quarterly net growth, which can provide for a better understanding of how quarterly increases in gross enrollment and disenrollment impact MAPP's overall net growth.

Retrospectively it can be seen that net growth rose slowly until the beginning of 2002, likely following implementation of a far more efficient and effective automation of the

¹⁰ Source: Calculations for enrollment analyses derived from the Member Universe, Wisconsin Medicaid Data Warehouse.

eligibility process. In 2006, after a period of strong growth, quarterly participation rates began to slow, particularly in 2007 and 2008.

Figure 2



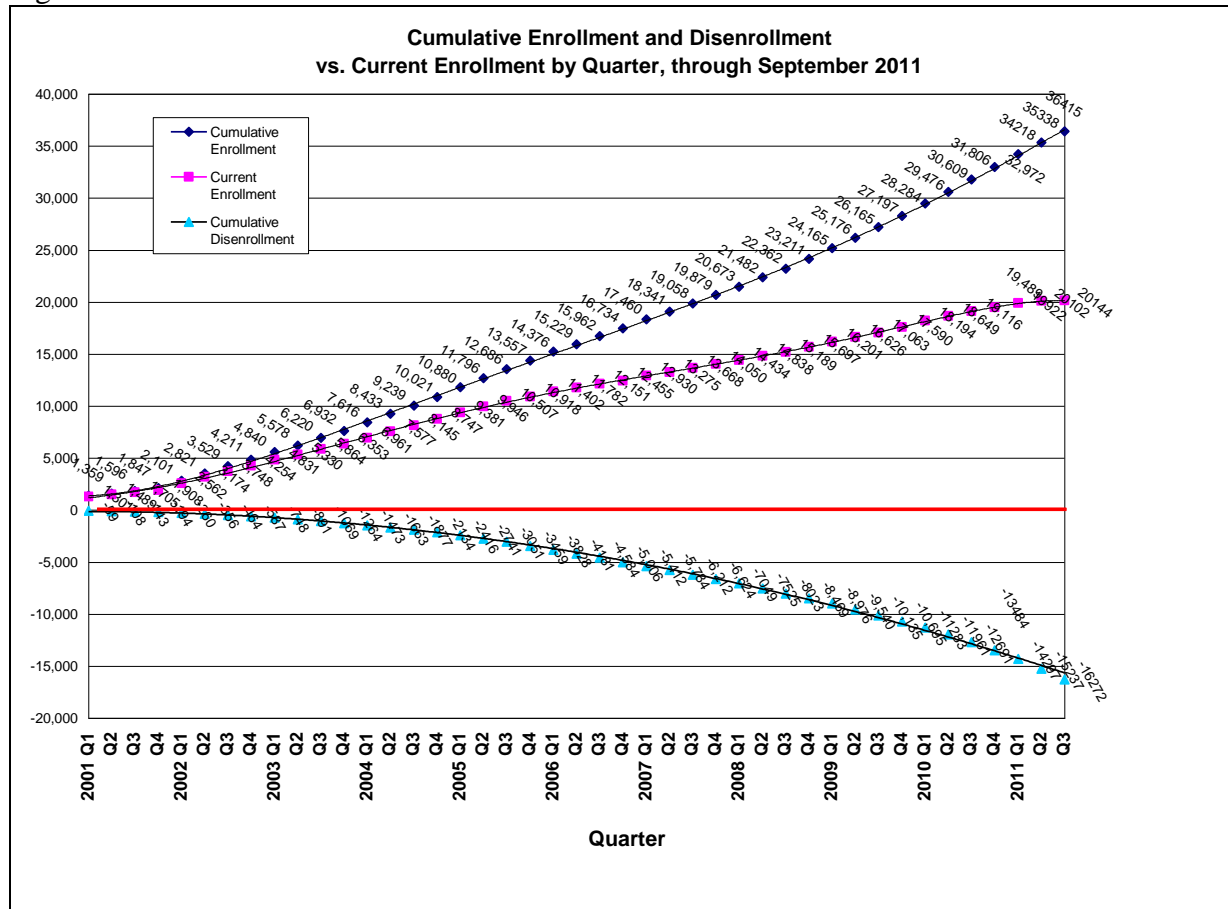
*Cumulative Enrollment and Disenrollment by Quarter*¹¹

Figure 3 provides information on current enrollment, cumulative enrollment and cumulative disenrollment. The top line on the chart shows that MAPP enrollment remains fairly consistent; however, the number of disenrollees flattens the slope of the current enrollment line. Though it is still trending upwards, it is doing so at a slower rate.

The middle line—current enrollment—demonstrates subtle changes in an otherwise consistent growth pattern. These subtle waves echo the variance of quarterly net growth seen in Figure 2.

¹¹ Source: Calculations for enrollment analyses derived from the Member Universe, Wisconsin Medicaid Data Warehouse.

Figure 3



Age and Gender¹²

The ratio of males to females enrolled in MAPP has changed somewhat over time. In 2001, slightly more than half of those enrolled (55%) were male. In 2005, males and female participation MAPP was evenly split at 50%. Five years later, there were slightly more females enrolled than males (52% vs. 48%). Figures 4 and 5 show how the composition of age and gender has changed over time.

The percentage of MAPP participants who fall into different age categories has changed over time. This change in distribution was due to a large growth in older participants (55 and older) and a slower increase in participating adults who were 25 to 44 years old, thus decreasing their proportional make-up of the MAPP population. Two age categories demonstrated a more steady growth, proportional to the overall increases in MAPP participation (individuals 45-54 and less than 25). The percentage of MAPP participants

¹² Source: Member Universe, Wisconsin Medicaid Data Warehouse.

who were 55 or older almost double in ten years, whereas the percentage of MAPP participants who were between 25 and 44 decreased by almost half in the same time period.

Figure 4

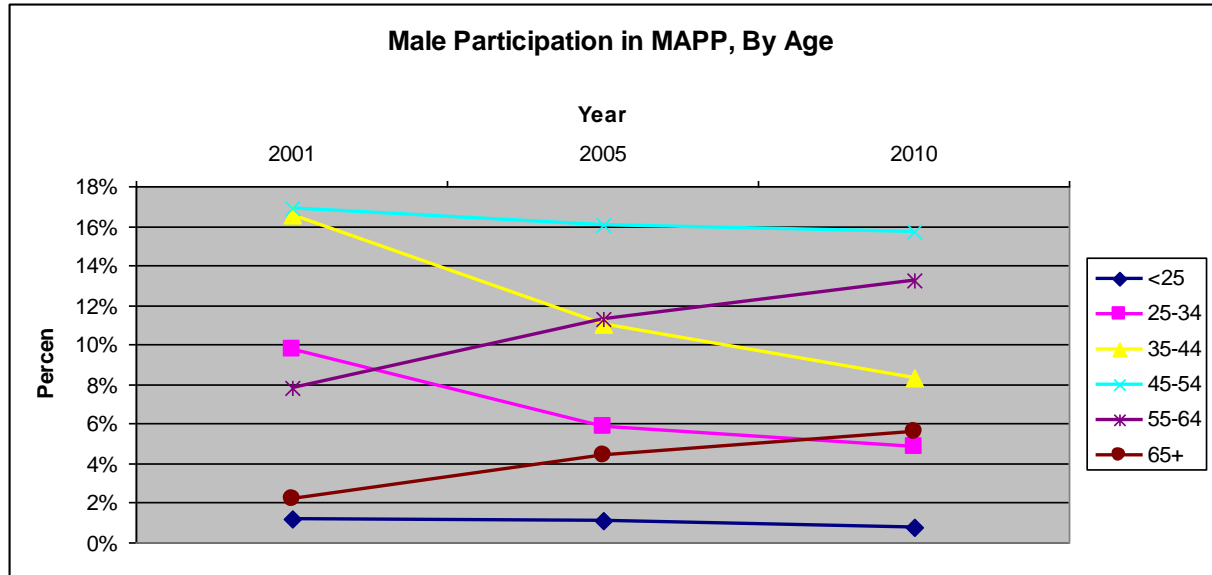
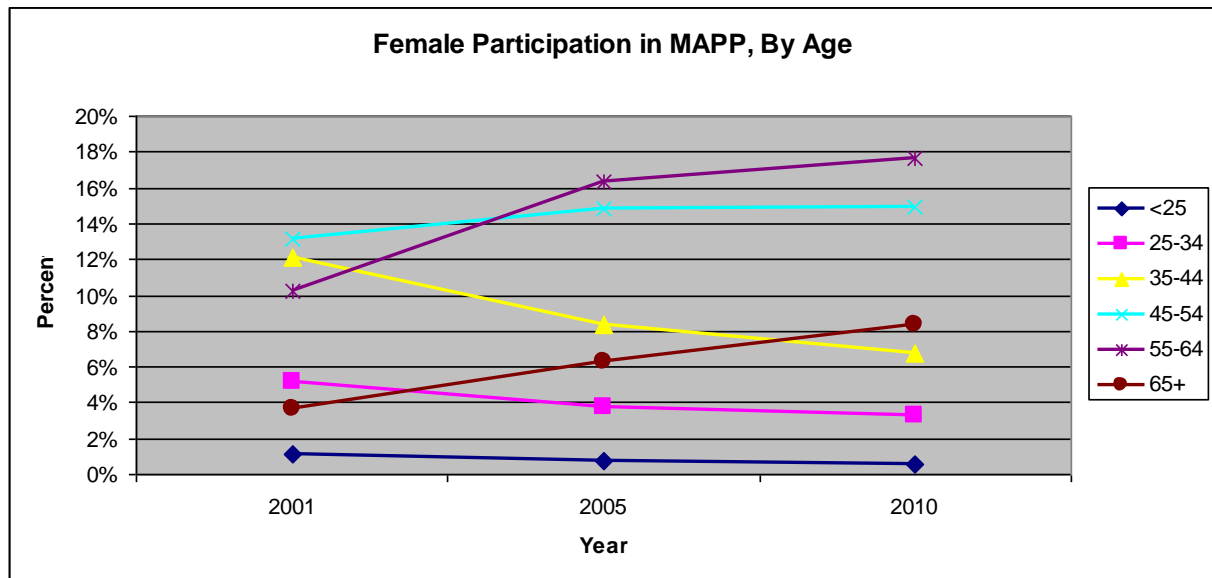


Figure 5



The participation of men and women followed similar trends in terms of age categories; however, the strongest trends seen over time was the increased percentage of participation of women aged 55 to 64, and the decreased percentage of participation of men aged 35 to 54.

*Premiums*¹³

Through December 2011, just under \$16 million in MAPP premium payments had been assessed. The average premium payment among those participants assessed a premium in 2011 hovered around \$240/month. Table 2 below shows the monthly totals of premiums assessed each month in 2011, for a yearly total of nearly \$2.5 million.

Table 2

2011 Monthly Premiums Totals	
Month	Total Premiums Assessed
January	\$173,669.40
February	\$195,913.20
March	\$202,446.44
April	\$193,981.30
May	\$193,810.26
June	\$203,824.82
July	\$202,140.08
August	\$209,827.66
September	\$207,205.69
October	\$216,943.25
November	\$204,782.76
December	\$215,037.56
2011 Total	\$2,419,582.42

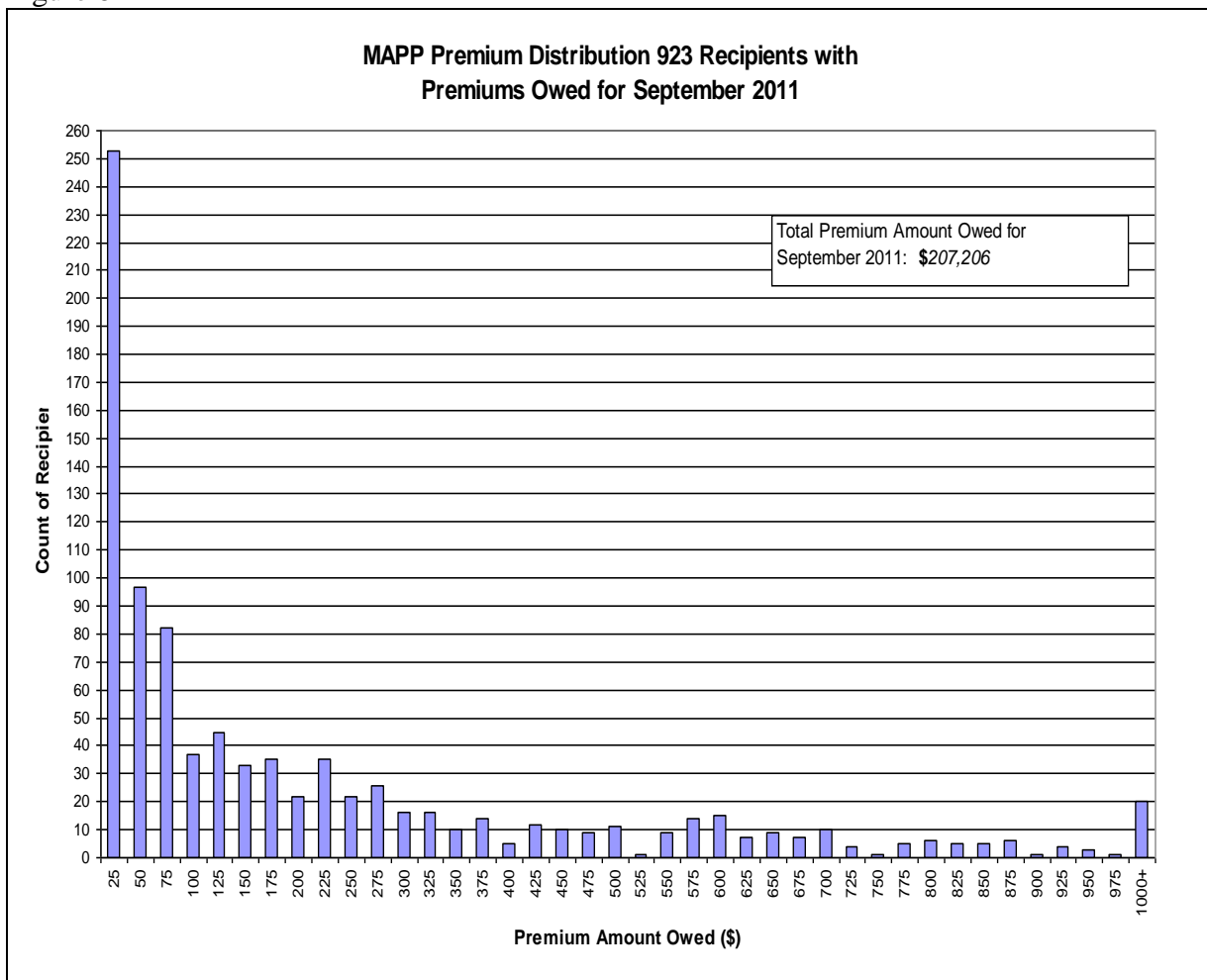
Figure 6 below illustrates the number of premium payers in each of the premium categories for the month of September 2011.

The largest group of premium payers continues to be the \$25 group (N = 253), comprising nearly one-quarter of all members assessed a premium (N = 923). Historically, this group has comprised about one-quarter of premium paying members.

The percentage of MAPP participants assessed a premium has decreased substantially over the last ten years. In 2002, about 16% of those enrolled in MAPP were assessed a premium. In 2011, this percentage had fallen to 4%. There are several reasons that might have contributed to this downward trend over time, although none have been thoroughly investigated. For example, anecdotal evidence showed that many MAPP participants were unable to afford premiums; therefore, they might have ensured that their earned income did not grow to a level at which a premium would be levied. Indeed, as will be seen in a later section, earned income has fallen steadily over the last ten years, and is strongly correlated to the number of premium payers. Although some participants might have learned how to apply deductions to income (e.g., MRWEs and IRWEs, to be discussed in the following section), it is unlikely that this would have had such a large impact on the number of individuals without a premium.

¹³ Source: Member Universe, Wisconsin Medicaid Data Warehouse.

Figure 6

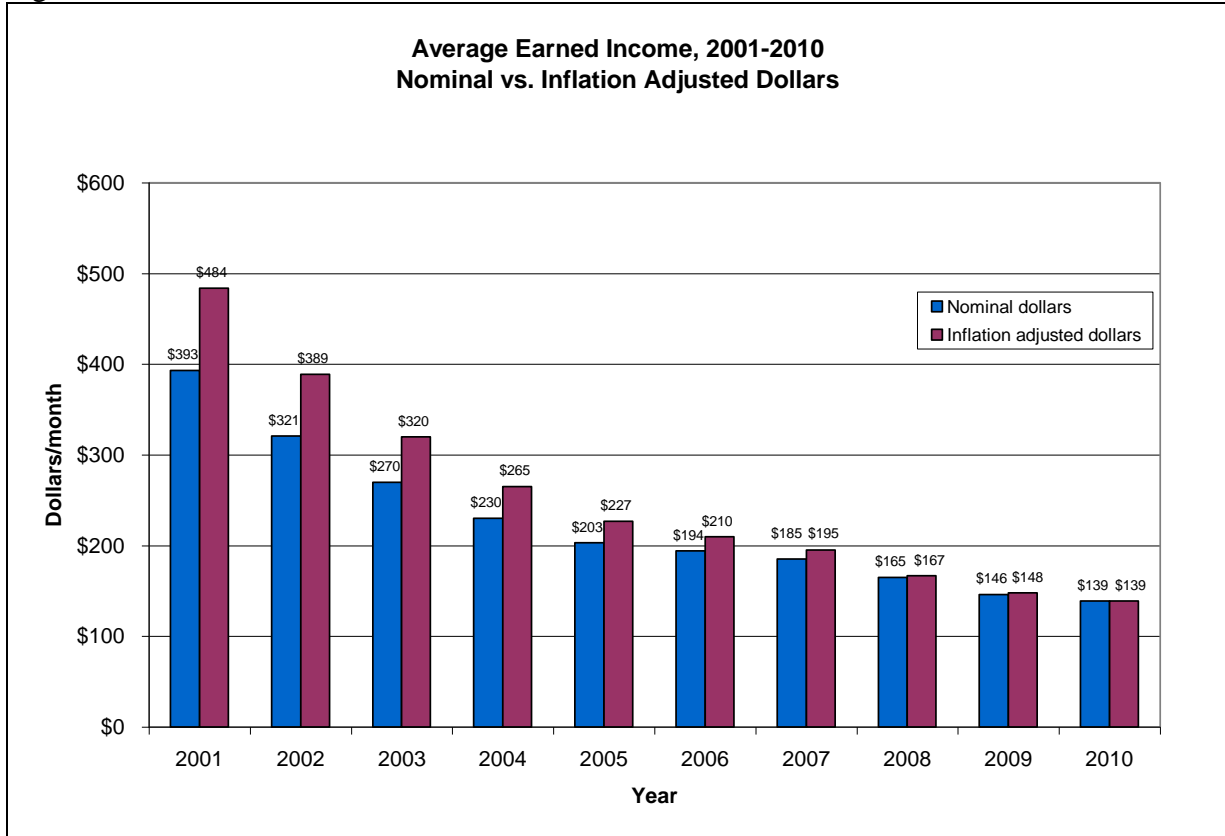


*Earned Income*¹⁴

In December 2011, MAPP participants had gross earned income ranging from \$0 to \$5,395 per month, with an average of \$139 per month and median of \$21 per month. These figures represent a continued decline from previous years. Figure 7 shows the downward trend of earned income over the years.

¹⁴ Source: December 2010 CARES data

Figure 7



Comparing nominal dollars over the course of ten years provides a somewhat distorted picture of earned income due to inflation. Figure 7 shows the nominal earned income averages as well as the average earned incomes after adjusting for inflation. After inflating pre-2010 dollar amounts based on the Consumer Price Index (CPI), the decrease in earnings over the years becomes more pronounced¹⁵. Unadjusted, participants in 2001 earned an average of \$393 per month, an amount that fell to \$139 in 2010. Adjusted for inflation, the decline appears steeper, falling from \$484 in 2001.

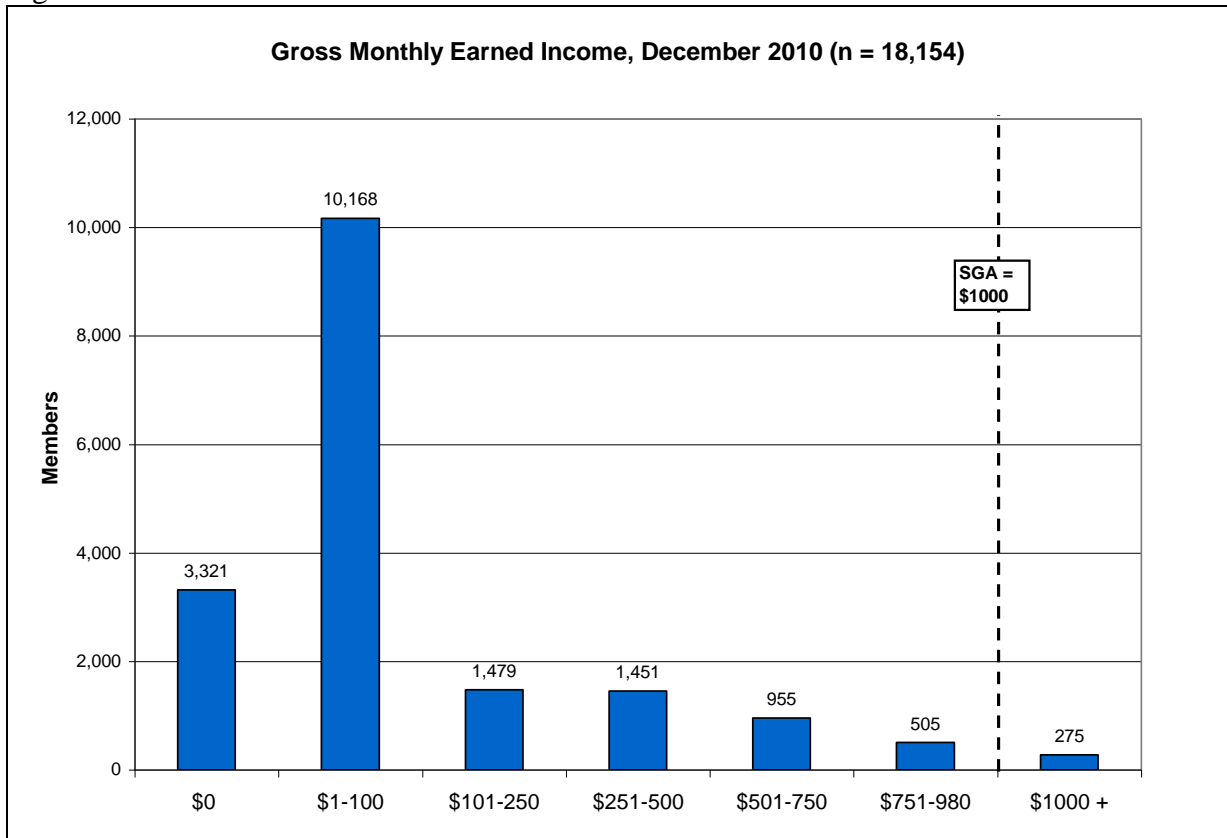
Possible reasons driving the sustained decrease in earned income have been suggested over the years. The consistent decline likely reflects characteristics of new participants, most of whom entered MAPP with very low cash earnings from work. It might also reflect decreased earnings among those participants with longer program tenure. The downward trend in earned income also coincides with an upward trend in the average age of participants, suggesting that some retirement age participants might be reducing their earned income. Or, new enrollees include more seniors with less interest in substantial employment.¹⁶

¹⁵ Consumer Price Index from Department of Labor Statistics

¹⁶ These individuals would be able to maintain MAPP participation if in-kind income was still being collected.

Figure 8 shows the distribution of participants by the amount of their monthly earned income. Of the 18,154 individuals for whom earned income data were available in December 2010, 1.5% (275) were earning at or above the level of substantial gainful activity (SGA)¹⁷, with the remainder falling below—most far below. This percentage has decreased each year, from nearly 4% in 2001. About 74% of MAPP participants in December 2012 had an earned income of \$100 or less, up from 72% one year prior.

Figure 8



The percentage of MAPP participants reporting no earnings has increased consistently over the last ten years. In 2007, 13% of members reported zero earnings. In 2010, this percentage had climbed to 18%. Although it is possible that some of these participants are not employed, there are other possible explanations. For example, no earnings may be related to enrollment in HEC. Zero earned income may also reflect a health-related leave from employment. Additionally, MAPP allows participants to engage in in-kind employment for which wages are not reported. Finally, some observers suggest that the work requirement is simply not enforced.

¹⁷ \$1000/month in 2010. SGA is used as the threshold to separate people as several benefit rules are tied to it, MAPP eligibility *not* being one such benefit.

Other than the number of higher earners and lower end earners ticking downward and upward respectively, the overall trend looks quite similar over the last five years. Most apparent is the number of earners falling between \$1 and \$100; this spike has been present on every earned income chart since they were introduced as a recurring feature of evaluation reports.

Unearned Income¹⁸

The majority of MAPP participants are receiving one or more cash benefits, termed for premium purposes as “unearned income.” Unearned income includes Social Security benefits, disability benefits and pensions.

In December 2010, of the 18,154 participants enrolled in MAPP, 17,841 (98%) received one or more unearned income payments. Most payments were classified as SSDI, although there were several other types paid less often including social security child disability and social security retirement payments. The highest payment was \$5,000/month although this appeared to be an outlier with most of the higher payments in the \$2,000 range. The average monthly payment was \$942 and the median was \$953.

After deductions—including the standard living allowance and any IRWEs and MREs—the remainder of one’s unearned income is added directly to the amount of premium due. For this reason, it is unlikely that individuals with higher unearned income would find MAPP a feasible option, as the burden of relatively high premiums would outweigh the benefits of participating. Due to this differential treatment of earned and unearned income, the impact of unearned income on one’s premium payment is heavy.

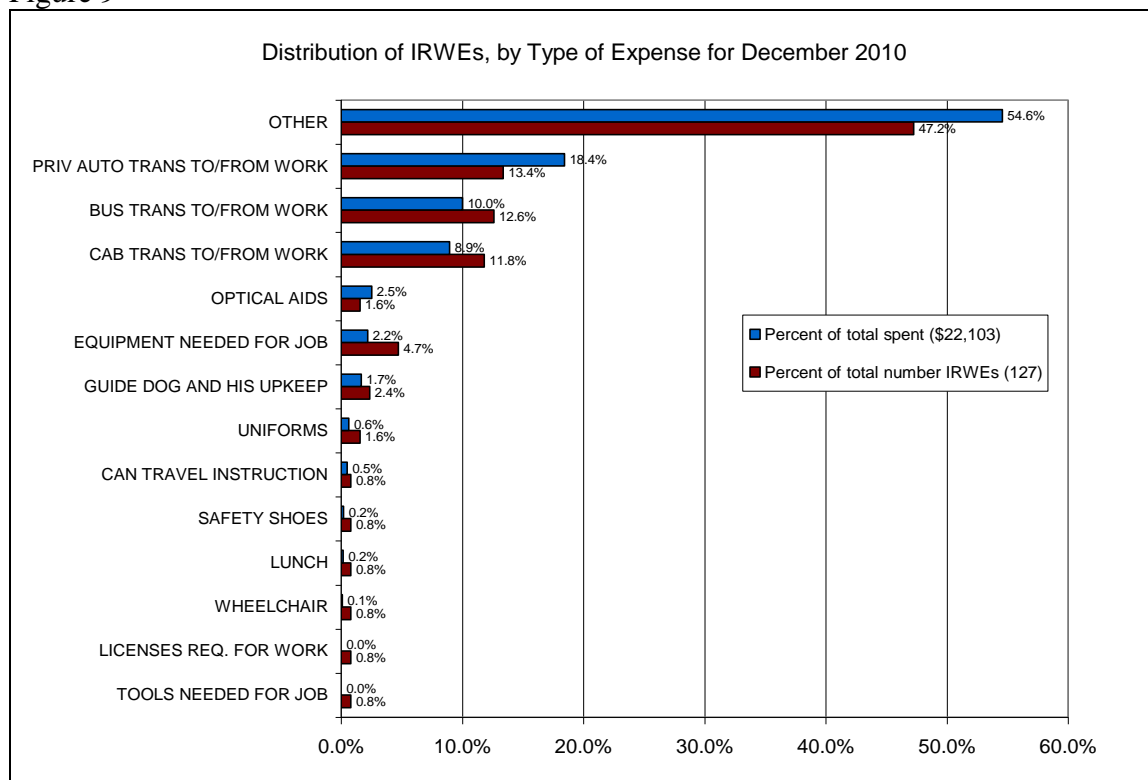
MRE and IRWEs¹⁹

As demonstrated earlier in this report, MAPP participants are allowed to deduct IRWEs from their income for the purpose of calculating financial eligibility and premium amounts for MAPP; participants are also able to deduct MREs for the purpose of calculating premium amounts. Information on MREs and IRWEs is collected by ES Workers as part of the MAPP application process. Detailed lists of IRWEs and MREs can be found in Attachment C in Section VI Appendix.

¹⁸ Source: December 2010 CARES data

¹⁹ Source: December 2010 CARES data

Figure 9



Consistent with prior years, it appears that very few participants reported MRE or IRWE expenses in 2010. December 2008 CARES data indicated that only 0.8% of MAPP participants report IRWE expenses. December 2009 data shows that the number of members reporting IRWEs declined to just 117 of 15,990 members, or 0.7%. The most current data from December 2010 shows a continued decline to 102 or 0.6%.

The minimum expense identified was \$1, the maximum \$3,698. The average IRWE expense in 2010 was \$174, the median was \$80. While the average IRWE has fluctuated slightly over the years, for the last few years the median has hovered around \$80.

Figure 9 categorizes the 127 reported expenses representing 102 participants by category as reported in CARES. Annual reports of the last three years show about the same number of IRWEs reported by about the same number of participants. This suggests that for the most part, the same people might be using this benefit from one year to the next. Although an extensive analysis has not been conducted to test this, preliminary examination does show that many of the MAPP participants claiming IRWEs in 2010 did so in the year or two prior as well.

The frequency with which the “Other” category is used (54%) limits the ability to use this data source to assess the needs of MAPP participants in terms of work-related supports, since it provides very little information. Transportation expenses (private car, bus, cab) accounted for 40% of all dollars spent on IRWEs, almost double the percentage from one

year before. Added together, the remaining categories comprised 15% or less of the total number of individuals reporting IRWEs plus 8% or less of the total spent on IRWEs.

Of 18,154 MAPP members, 1,068 (5.9%) reported a total of 1,103 MREs in December 2010, about the same as one year before. During the first few years of MAPP, a greater percentage of individuals reported MREs (e.g., 10% in 2002) but the usage more recently has hovered around 5.5%. The sum of all MREs reported in December 2010 was \$77,728, down substantially from years immediately prior (e.g., \$124,638 in 2009 and \$130,544 in 2008).

The average MRE was \$70 (median \$27) as compared to \$135 (median \$30) in 2009 and \$161 (median \$30) in 2008. The median tells a more accurate story – it has remained constant since 2007 even though the average MRE has fluctuated widely. In reviewing the data, it is seen that an outlier pulled the average up in 2008 and 2009, with a reported MRE of \$52,000 each month in 2008 and 2009. Of the 923 MREs reported in December 2009, all but six of them were less than \$1,000. It is likely that the most recent December 2010 data reflects a more accurate picture of MRE usage.

Unfortunately, the format of MRE data limits the type of analyses performed. Locally-based Employment Support (ES) workers enter data into CARES as “out of pocket / remedial”; therefore, there is no way of identifying the types of expenses incurred by MAPP participants.

County ES workers have had several years to become familiar with the IRWE benefit, yet its use has remained minimal. MREs are used throughout Medicaid in other sub-programs and are more recognized among county workers. Low IRWE/MRE usage might relate to one of the purposes of IRWE/MREs and are collected by ES workers to reduce a member’s income when calculating the premium owed. Since very few participants are assessed a premium, reporting these expenses may seem unnecessary.

Independence Accounts

Once enrolled in MAPP, participants can establish Independence Accounts (IAs), which are intended to foster savings for items that increase personal and financial independence. By establishing an IA, MAPP participants can save earnings above the \$15,000 countable asset limit for the program. Total annual deposits to IAs cannot exceed 50% of gross earned income each year.

A one-month snapshot of Independence Account data from December 2010 showed the following:

- Seventy-four (0.4%) of MAPP enrollees had one or more IAs, with 93 total accounts
- The range of balance amounts was \$1 to \$14,101
- The average account balance was \$3,169 and the median \$1,698
- The total amount of dollars saved in IAs by MAPP participants was \$294,677

As surveys and anecdotal evidence have suggested, the main reason very few MAPP participants utilize this program feature is that they do not have extra money to save.

IV. Challenges, Responses, and Lessons Learned

Section Overview

The following section takes a retrospective look at the MAPP program focusing attention on the many challenges related to program participation, management, responses to the identified challenges, and any lessons learned.

The issues faced during implementation and early in the program's history were similar to those encountered by any new program, ranging from slow and laborious enrollment processing to policy debates centering on such things as the definition of "employed" and identification of alternative premium methodologies. Across time the nature of the challenges and questions posed became more focused and refined. The following narratives illustrate several of the program's major challenges of the last 12 years, describe the department's strategy in addressing each challenge, and include any lessons learned through the work involved.

As mentioned earlier, MAPP was designed with three primary goals in mind. Two goals focus primarily on outcomes, while the third goal focuses on qualitative aspects of the program that relate to how the program was implemented and subsequently administered. Because these process-related issues occurred earlier on, it is helpful to discuss challenges related to the process goal before discussing outcomes of the program.

Goal: Offer an effective, efficient and equitable program to allow people with significant disabilities the opportunity to work without jeopardizing their health care coverage.

Challenges Identified:

- Impact of manual eligibility determination and other early programmatic issues that resulted in mixed success in achieving equitable service across the state, and
- MAPP's premium structure, criticized by some as being inequitable, interfered with MAPP functioning as a work incentive and thus had an impact on the program's effectiveness.

MAPP was introduced in March 2000. As is expected of any new program, several major process issues arose this first year. Significant challenges are outlined below, along with the program responses that most directly addressed each challenge. Findings and lessons learned are also provided as insight into possible solutions or ideas to inform the program overall.

Impact of manual eligibility determination and other early programmatic issues that resulted in mixed success achieving equitable service across the state

The MAPP program was implemented without making changes to CARES, the automated system used by counties to determine eligibility for Medicaid and other public assistance programs. Because MAPP eligibility was not automated in CARES when the program was first implemented, eligibility was determined manually. There were several issues that arose as a result of this.

A database for capturing data from the paper MAPP application in an electronic format was developed. This database allowed the evaluation of the program, including an assessment of the ES workers' accuracy in completing the application forms. Upon review, it was found that ES workers did not consistently complete application forms correctly, resulting in incorrect eligibility determinations and premium calculations. As such, the ES workers themselves directly impacted eligibility. In some counties, particularly Milwaukee County, there were reports that it was difficult for potential MAPP applicants to access the program because county ES workers did not understand the program eligibility requirements or were unavailable to process an application.

As a result of the manual eligibility determination process, ES workers incorrectly calculated the premium for a number of MAPP enrollees across the state. In the majority of the cases, the worker tested the applicant for premium liability using his/her adjusted family income, rather than their individual gross monthly income. Approximately 10% of applications contained this error. As a result, there was a chance that an individual was incorrectly categorized as eligible for MAPP with no premium. Additionally, there was confusion over whether or not premiums of less than ten dollars were to be assessed—in some cases they were, in others they were not²⁰.

The Center for Delivery System Development (CDSD) relied on counties to submit the paper forms to provide information to be used for monitoring and evaluating the program. Just over half were submitted on time, which limited the ability to effectively monitor and evaluate the program.

Automating MAPP enrollment was key to creating greater efficiency and accuracy for eligibility determination. Automation via CARES began in the fall of 2001, and was effective in alleviating many of the challenges related to manual eligibility determination.

In addition to automating MAPP enrollment, ES workers and Work Incentive Benefit Specialists (WIBS) provided feedback about MAPP via interviews, focus groups, and surveys. ES workers agreed that MAPP was helping people in their community and most respondents felt the program was working well for the people it was able to reach.

²⁰ After resolving that there would not be premiums assessed less than ten dollars, refund checks were issued to those members who had paid these premiums.

However, they also agreed that there was a need for additional outreach to identify and enroll more people who might be eligible for the program.

Lack of outreach to both potential enrollees and possible referral sources, such as social services workers, and publicity for MAPP were identified as program weaknesses. The counties themselves did not report that they were engaged in any concerted outreach efforts. ES workers were also concerned about the administrative burden of the application process as it was viewed as overly complex and cumbersome. The lack of additional resources to support the administration of MAPP was also identified as a shortcoming. In addition ES workers and WIBS reported:

1. MAPP administration had been “disjointed” at the county level
2. County staff exhibited varying levels of understanding regarding program policies and eligibility criteria
3. Additional training to county ES workers and additional outreach among potential program recipients were needed
4. MAPP was slowly becoming more effective, efficient and equitable across the state
5. A general lack of client access to ES Workers who understood the MAPP program
6. MAPP premiums were said to be unaffordable for individuals who had high levels of unearned income relative to their earned income (e.g. individuals receiving SSDI payments).
7. While county workers appreciated certain aspects of the work requirement, such as the flexible definition of “work,” there were concerns about other aspects of the work policies, specifically the work exemption policies.
8. Inflexible policies given the health needs of the individuals eligible for the program. This is a group that frequently gets sick and may need to take off work for a period of time. A suggestion was made to modify the requirement so that individuals would be required to work for at least six months out of the year to qualify for MAPP (i.e., allow for a total of six months of work exemptions in each year). WIBS suggested that they would be better served by a policy that protects the participants for more frequent, but shorter periods of illness that prevent them from working.

Another concern was limited enrollment in MAPP’s Health and Employment Counseling (HEC) program. Employment Resources, Inc. (ERI) administered this program and identified the following factors as contributing to limited MAPP enrollment through the HEC program:

1. HEC screeners had full-time duties with their employers and did not have a strong identification with the program
2. Insubstantial and ineffective marketing support for MAPP or HEC

3. Limited outreach to the disability community, and
4. Insufficient availability of benefits analysis and planning

ERI proposed improvements to the HEC screening process for year two of the MAPP program. Utilization of Regional HEC Screeners with extensive knowledge of disability benefits analysis and planning was expected to provide a more effective and efficient screening process for enrollment in the MAPP program.

To address the underutilization of HEC, a considerable amount of effort was directed toward improving outreach for HEC. In most cases, the HEC screeners reported having difficulty finding the necessary time to promote HEC because they were kept busy answering general questions about MAPP. Despite these efforts, HEC continued to be underutilized.

A significant number of MAPP participants reported \$0 in earned income, but were not enrolled in the HEC program. This raised concerns about the coordination of MAPP and HEC, and questions about whether or not ES workers were verifying employment and making appropriate HEC referrals. It was also possible that MAPP participants had \$0 in earned income because they were receiving in-kind compensation for their work.

Although HEC was underutilized, it was helpful for those who had accessed the program. The HEC screeners provided HEC enrollees with basic MAPP information, informal and formal benefits counseling, links to Division of Vocational Rehabilitation (DVR) and area job centers, and the development of job goals. In addition, MAPP received invaluable outreach and community/provider education through HEC, neither of which was to be found elsewhere in MAPP.

Utilization was related to several structural barriers built into MAPP, most notably the acceptance of in-kind income to meet the work requirement; the lack of resources to conduct thorough verification of employment among program participants; and the lack of resources to provide vocational services as part of MAPP. The basic structure of MAPP worked against its own success by limited enrollment into HEC.

A final set of strategies was developed to tackle the issues related to HEC underutilization. They included:

1. A proposed revision of the definition of work was created that met the needs of MAPP and also fit within current federal buy-in guidelines. It was expected that this would help ES workers to verify employment and make the appropriate HEC referrals, but this did not occur.
2. The hiring of additional Regional HEC screeners and a Statewide HEC coordinator. All new screeners had experience with disability benefit issues, benefits analysis and counseling, service and supports available to consumers with disabilities, and familiarity with disability-related employment barriers
3. The initial HEC screeners were allowed to participate in the HEC screening process acting as HEC liaisons

4. Improved Outreach for HEC

Following these efforts, HEC refinement and reorganization substantially improved the consistency of MAPP administration across the state, as measured by outreach efforts and enrollment.

Premium structure

MAPP's premium payment requirement differentiates it from the majority of Wisconsin's Medicaid programs. Historically, there have been issues related to MAPP's premium structure since the program's inception. The main issue stems from MAPP's differential treatment of earned and unearned income in premium determination.

In Section II, an example of a premium calculation was given that showed how earned and unearned incomes are treated differently. Generally, the premium calculation formula dictates that one's premium liability does not increase proportionately to one's increase in total income; rather, it increases disproportionately with one's increase in unearned income. This sets up a situation in which individuals receiving an SSDI cash benefit (or any other substantial amount of unearned income) are subject to higher premiums, a disincentive for joining MAPP.

Early on the program's premium structure was criticized as being unfair, due to a heavy "tax" on certain kinds of income compared to other kinds. MAPP is a means tested program, and one rationale for means tested programs is that as one's income increases so does their ability to cover the costs of certain needs, such as health care. The eligibility criteria and premium schedule for MAPP are based on income as a percentage of the FPL. By setting the premium threshold at 150% of the FPL, the policy suggested that individuals with income above this level had resources available to support a percentage of their health care costs. It is the definition and distinctions around "income" for the purposes of the identifying premium amounts that made the premium calculation inequitable according to some.

MAPP applicants were expected to contribute 3% of their adjusted *earned* income toward their premium, while they were expected to contribute 100% of their adjusted *unearned* income. The effect of this was that individuals with the same total income, but with different ratios of earned and unearned income, could be paying significantly different premiums. Applicants with minimal employment and high unearned income would, in theory, be discouraged from participating in the program. In reality, this appears true. Recent CARES data showed that total unearned income did not exceed \$3,000 for an individual, suggesting that for many MAPP participants, there is an unearned income threshold that when exceeded results in a premium that is too high for individuals to manage.

Premium Calculation Case Study: *A MAPP applicant who applied in March 2001 with a large amount of unearned income relative to her earned income (\$1,040 unearned versus \$5 earned). Her total gross monthly income was \$1 over the 150% FPL threshold so she would be required to pay a MAPP premium. Her premium would have been \$400. A*

premium of this amount represents 38% of her gross monthly income. If the amounts of her earned and unearned income had been reversed, her premium would have been waived because it was less than \$25.

While some criticized the premium structure, others argued that the premium formula was structured to provide strong work incentives. In a memo addressed to Department of Administration staff dated October 21, 1998, DHFS recognized the differential treatment of earned and unearned income and identified it as a policy that builds work incentives into the premium structure. For example, SSI cash benefits are subject to an offset of \$1 for every \$2 earned. At the time MAPP was underdevelopment it was expected the SSDI program would soon have a similar offset in place. The impact of the offset would be a gradual reduction in unearned cash benefits as earned income increases. Thus, if MAPP were to “tax” unearned income at a higher rate than earnings, it would further motivate beneficiaries to work and earn more, as their MAPP premium would go down proportionally.²¹ The memo also stated that another advantage of the premium structure is that it targets people who can and will work at a substantial level.

At the time of the Year One annual report, policy modifications were already being discussed. The State was in the process of evaluating and considering alternatives to the current premium formula. One proposal under consideration was to mirror the premium calculation used for the BadgerCare program and eliminate the differential treatment of earned and unearned income.

Earned and unearned income amounts were reviewed for MAPP enrollees who had an application on file to determine if MAPP was reaching its intended audience and to measure the success of the premium structure as it related to work incentives.

This issue of differential treatment of earned and unearned income continues to be an ongoing program challenge. As of 2011, MAPP policy remained unchanged with respect to the treatment of earned and unearned income despite numerous efforts throughout the years to demonstrate the seeming work disincentive built into the formula.

Goal: Encourage people with disabilities to earn more income.

- Reduce participant fears of losing health care benefit
- Address barriers that inhibit MAPP participants from working and earning more
- Utilize employment supports to mitigate barriers to employment
- Encourage participants to work and earn more
- Determine if MAPP is cost effective
- Determine the fiscal impact of MAPP on other Medicaid and long-term care spending, and
- Assess the value of program participation for higher earning participants

²¹ The SSDI offset at \$1 for \$2 earned was not implemented and is undergoing testing in ten areas nationally at the time of this report.

The main impetus behind the development of MAPP's second goal was to highlight the need to create a working environment for people with disabilities that did not contain a disincentive to earn and save money. Under regular Medicaid, restrictive income and asset limits serve as a disincentive to earn and save money, as these savings quickly become subject to spend downs in order for individuals to retain health care coverage. To remove this disincentive from the work-health care relationship, MAPP was designed with more liberal income and asset limits. Although higher earners are more likely to be assessed a premium (depending on unearned income) and more likely to risk losing other benefits (e.g., social security disability payments), their health care coverage is secure as long as they are participating in MAPP.

Assessing "success" in reducing participant fears of losing health care benefit

Perhaps the most persistent challenge relating to MAPP's second program goal has been relieving the fear of losing one's health care benefit. The natural reaction to this fear of benefit loss is to work and earn less in an effort to maintain health insurance.

Several program features were designed to alleviate this fear and encourage working, including higher income and asset levels. In addition, various deductions are available (e.g., impairment related and medically related work expenses) that serve to reduce countable earnings.

With so much of the program's success depending on the reduction of the fear of benefit loss, it follows that this challenge has been revisited several times. MAPP participants were surveyed while enrolled and after they disenrolled from MAPP. Results suggested that MAPP did reduce anxiety over losing health care benefits after initial enrollment; however, anxiety was still high and the open ended comments suggested that at least some respondents maintained some fear of losing health care benefits after enrollment. Prior to MAPP enrollment, over 77% of respondents were at least "a little afraid" of losing their Medicaid coverage if they began working. This fear appeared to reduce a little bit as 71% of follow-up respondents feared losing health care coverage.

Although MAPP appeared to be reducing fears related to returning to work or increasing work, it was clear that most respondents did not understand MAPP to be a work incentive program, but rather, as another option under which they could receive state sponsored healthcare coverage. Many of the open-ended comments showed great appreciation for the program, as it was the only health care coverage available to them (other than Medicare), but very few mentioned anything about work, except ironically to say that the work requirement was confusing and should be dropped.

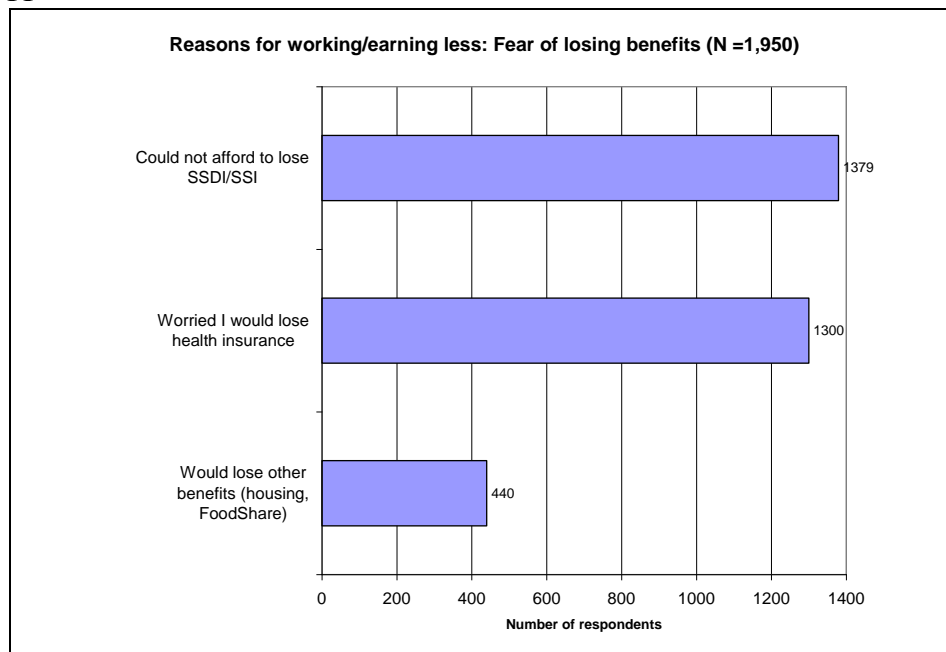
Fear of losing health care benefits might also have been allayed somewhat due to external factors, including benefits counseling, which can help participants navigate the complex relationships between employment and benefits. But despite these efforts the level of fear among MAPP participants remains high..

Before being deemed disabled and eligible for related disability benefits (including SSI, SSDI and Medicare), an individual must prove he or she cannot work. By placing this

onus upon the individual, which may also lead to an arduous disability determination process, a dynamic of mistrust can be created between an individual and the SSA and/or DHS. When these same agencies encourage employment, as is required for participation in MAPP, it is not surprising that individuals would question these agencies' motives in encouraging employment. As long as the disability determination process focuses on the applicant proving an inability to work, it is likely that a degree of mistrust and fear related to DHS and SSA efforts to encourage a return to work will remain.

Five years later (2007) MAPP participants were gain surveyed. Figure 11 shows how MAPP enrollees perceived the fear of losing benefits as a barrier to working or earning more. At least 60% of all respondents said they were worried about losing health insurance, and about 70% of respondents said they could not afford to lose their SSDI or SSI cash benefit. Again, these findings corroborate what has been known anecdotally for some time—the majority of MAPP participants likely worked or earned less because they did not want to lose health and cash benefits.

Figure 11



The survey ought to untangle the fear of losing health insurance from the fear of losing other benefits. Figure 11 suggests that the fear of losing health insurance is almost, but not quite, as extensive as the fear of losing a disability related cash benefit. The receipt of even \$1 more than the SGA level threatens the entire cash benefit for SSDI beneficiaries.²² Known as “the cash cliff,” beneficiaries are hypothesized to experience a disincentive to work beyond the level of SGA.

Although survey respondents clearly indicated a fear of losing their health benefit if they worked or earned more, there is somewhat of a disconnect between the pervasiveness of

²² The benefit is not lost until after the completion of a nine-month trial period of working above SGA.

this fear and the actual number of MAPP participants earning at a level that even remotely approached SGA. A large majority of participants showed a sustained lack of earnings, and it is questionable that a fear of losing benefits explains the lack of earnings. While it certainly might represent a barrier to working and earning more, it is likely that there are other factors as well acting as disincentives to earn more.

Assessing success in addressing barriers that inhibit MAPP participants from working and earning more.

Although the fear of losing benefits was a large barrier that prevented MAPP participants from working and earning more, it was not the largest barrier. Both the 2002 and 2007 surveys showed that above all other factors, MAPP survey respondents perceived health reasons as the greatest barrier to working or earning more. In the 2007 survey health related barriers, “physical limitations” was the answer most frequently chosen, with about one-third of respondents selecting it. “Poor mental/emotional health” was also a frequently chosen response, with about one-quarter of all respondents choosing this.

Figure 12

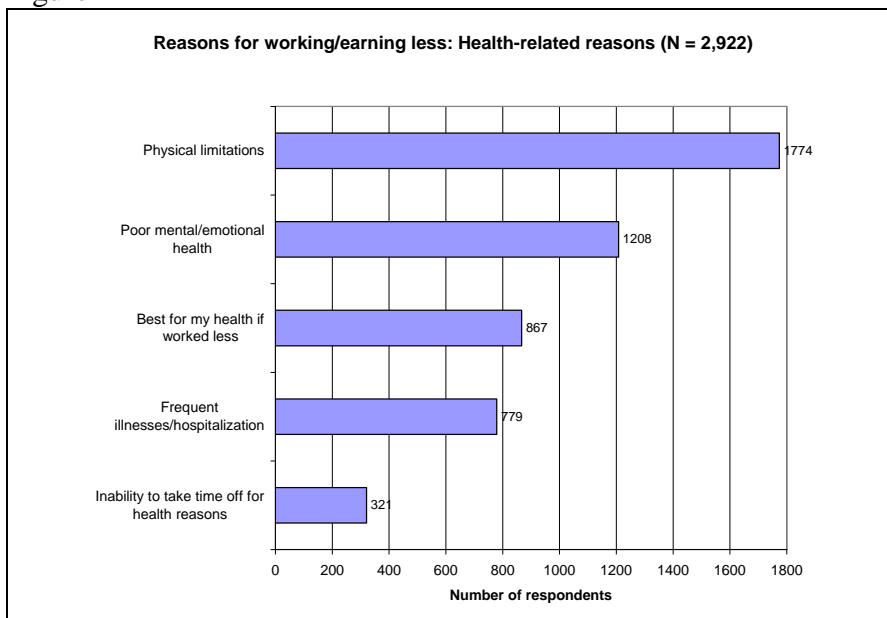
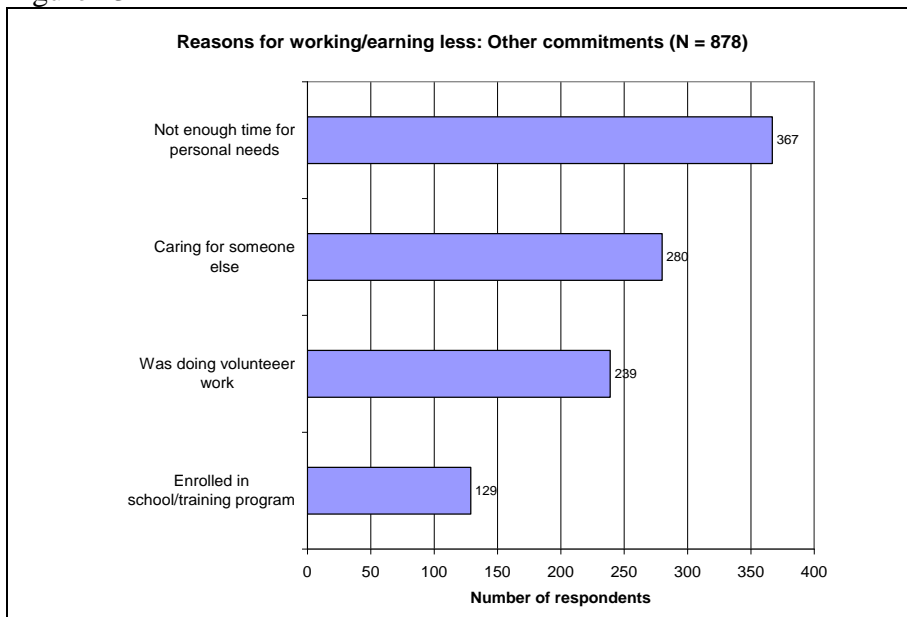


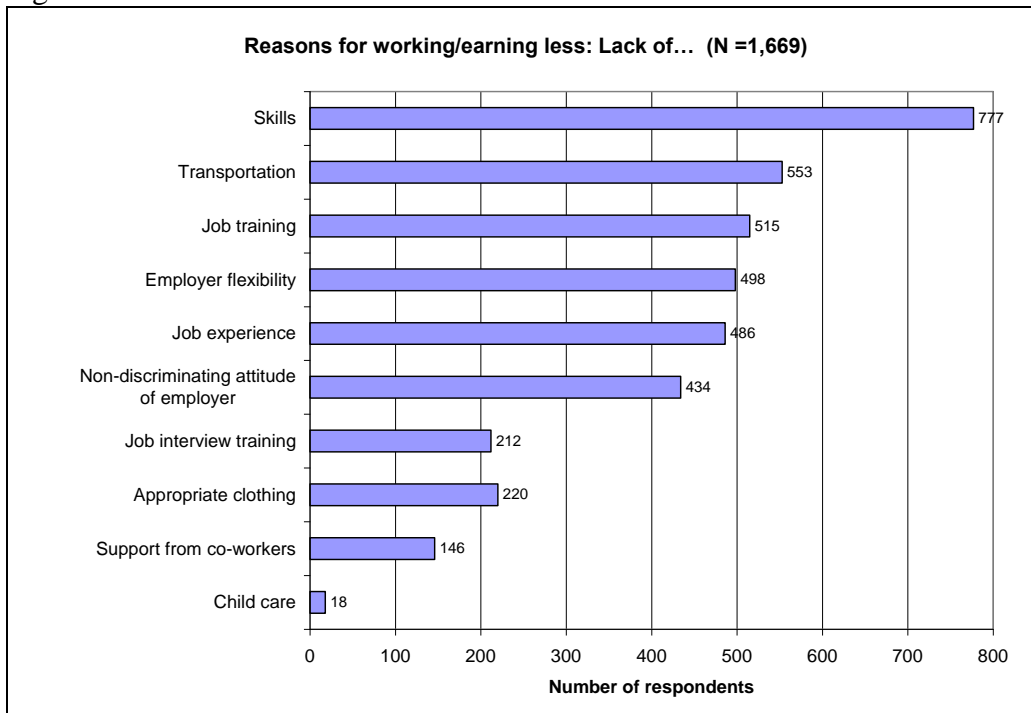
Figure 13 shows how 878 MAPP survey respondents perceived other commitments as barriers to working or earning more. “I would not have enough time for personal needs” was the most frequently chosen response. “Caring for someone else” and “doing volunteer work” were selected by about one-quarter of respondents. The least frequently selected response was “enrolled in school or training program.”

Figure 13



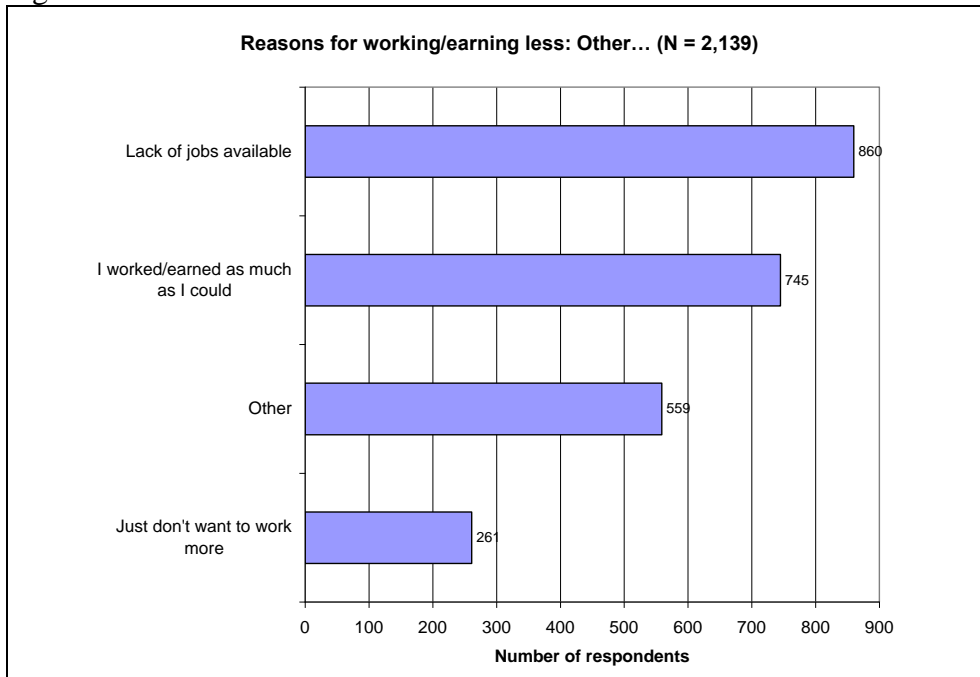
Some respondents (35%) also reported not working more due to a “lack of skills”. Respondents also reported not working more due to a lack of transportation, lack of employer flexibility, and lack of job training and experience. About one-third of respondents claimed that their employer had a discriminatory attitude toward people with disabilities. Very few respondents reported lack of child care as a reason for not working more.

Figure 14



Respondents also reported they were not working more due to lack of jobs available. Some participants simply did not want to work more than they already were.

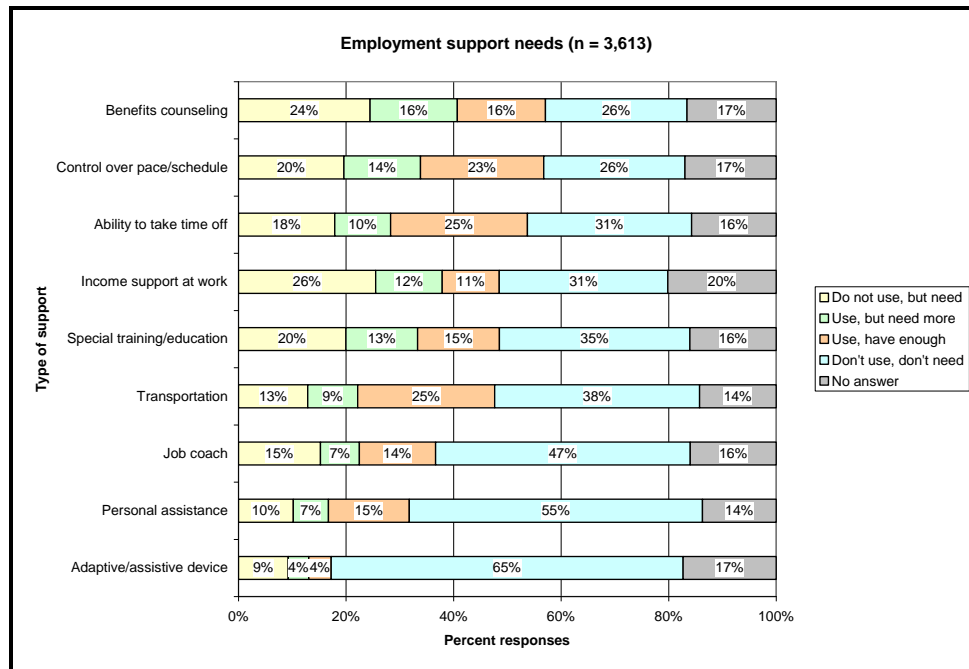
Figure 15



Determining if and to what extent, employment supports mitigate barriers to employment

Results from the survey suggested that lack of employment related support might have served as a barrier to working or earning more. Figure 16 presents each type of employment support in order of greatest unmet need. The greatest overall need (first three segments combined) appeared to be for benefits counseling. Following benefits counseling, control over pace/schedule, ability to take time off, and income support at work were the most needed supports.

Figure 16



An additional goal of this analysis was to determine how level of earned income (i.e., none, low, high) interacted with each type of employment support. Earnings were based on Wisconsin unemployment insurance (UI) wage data²³. Survey results indicated that individuals earning at high levels rated their health as excellent, very good or good with a greater frequency than those earning at lower levels. In addition, low earners were less likely to be using employment supports. If more needs were met, perhaps the individuals could have engaged in more successful employment.

- *Benefits Counseling:* Benefits counseling, including services that help one learn how work affects SSDI/SSI, health insurance and other disability benefits, had both the greatest overall need as well as the most unmet need of any type of support with nearly 30% of respondents not using it but needing it, and 20% using it but requiring more.

Individuals without earnings were the most likely to indicate that they did not use benefits counseling because they did not need it, but they were also the group most likely to report that they did not use it but needed it.

²³ Wage data is collected from employers for unemployment insurance tracking and is compiled on a quarterly basis. UI wage data is a convenient source of earnings data that is easily linked to other data from the MEDS data warehouse. Wisconsin UI wage data excludes earnings from those who are self employed, employed by the federal government, or work in a bordering state. Additionally, because UI employment is reported quarterly, it is impossible to know the specific time period (e.g., months) during which an individual was actually employed.

- *Control Over Pace/Schedule*: The demand for greater control over pace and/or schedule was the second highest need after the need for benefits counseling, with nearly 70% of respondents indicating some level of need. Nearly 45% of respondents reported unmet demand for this type of support, i.e., they either used this type of support but needed more, or did not currently use it but needed it.

Those with no earnings were more likely than others to report not using this type of support because they did not need it. Also notable was the percentage of high earners who indicated that they had some degree of control over their pace and/or schedule but required more. This was indicated by nearly 38% of high earners, contrasting with about 17% who were satisfied with this level of support.

- *Ability to Take Time Off*: Responses showed a relatively high demand for the ability to take time off, and that a significant portion of this demand was unmet. About 34% of respondents said they either used this type of support but needed more, or did not currently use it but needed it.

Those with no earnings were understandably the least likely to use the ability to take time off as a support while the higher earners were more likely to use this. However, those without earnings were the most likely to choose the response indicative of the greatest need: those who do not use a support but need it. About 24% of those without earnings reported this, as compared to 18% of low earners, and 15% of high earners, the data also suggests that a quarter of those without earnings might be able to work more if given the ability to take time off.

- *Income Support at Work (Long-term Disability Insurance)*: There was no apparent relationship between earnings group and responses. About 47% of respondents indicated an unmet need for income support at work.
- *Special Training/Education for Work*: About 42% of respondents said that they did not require special training or education for work. Overall, about 58% of respondents express some need for special training or education to support their employment.

As seen with other types of support, both high and low earners were more likely than those without earnings to use this type of support. High earners were the least likely to indicate unmet need while low earners were the most likely to report an unmet need in this area. Just under 44% of low earners indicated an unmet need in this area of support.

- *Transportation to/from Work*: Of the nine types of support, transportation to/from work had the highest percentage of respondents who said they used it and were satisfied with their level of support. Unmet need was indicated by 26% of respondents. Together, this suggests that transportation is a better developed or better publicized type of support.

While unmet need for this type of support was overall less than was indicated for other types of support, those without earnings were again most likely to report not using this type of support but needing it.

- *Job Coach*: As compared to many of the other types of support, respondents expressed an overall lower demand for job coaching. About half of respondents said they did not use this type of support and did not need it. Similar to other types of support, those without earnings were the least likely to have reported using a job coach and the most likely to have reported “I do not use this type of support but need it.” The low reported usage combined with the higher percentage of “do not use but need” suggests that those without earnings may have been unaware that such supports existed, or that there were challenges in arranging this type of support.
- *Personal Assistance*: There was a lower demand for personal assistance as compared to most other areas of support. About 63% of all respondents indicated they did not need or use this type of support. Lower and non-earners were more likely than higher earners to report that they did not currently use personal assistance but needed it. It may be that higher earners, of whom only 14% reported a need for more personal assistance, knew more about the support services available to them and so reported a lower level of unmet needs.
- *Adaptive or Assistive Device*: Overall, respondents indicated less demand for adaptive or assistive devices than any other type of support included on the survey. Overall, 79% of respondents did not need or use this type of support. Similar to other types of support, non-earners were the most likely to indicate they did not use this type of support yet needed it, while high earners indicated the lowest level of unmet need across the three groups. Higher earners may be more aware of the supports available or may have better access to these supports. Higher earners also had the highest percentage of individuals who simply did not require adaptive or assistive devices.

Determining success in encouraging participants to work and earn more

Assessing actual earnings among MAPP participants has always proven difficult due to the lack of an available, comprehensive and reliable source of wage data; however, the recipient surveys provided some indication of average MAPP earnings and earnings trends over time.

Among initial survey participants in 2002, average self-reported earned income was greater than \$280 per month. More important, average annual income as self-reported in the recipient surveys showed a steady increase over time. Initial respondents reported earning \$3,299 per year, whereas the twenty-four month respondents reported earning \$4,147 per year. Although annual income was steadily increasing over time, the differences between groups were not significant.

There were disproportionately more \$0 wage earners in Milwaukee, Kenosha, Washburn and La Crosse Counties²⁴. In addition, Milwaukee and Dane Counties represented a disproportionate number of high wage earners.²⁵ As stated previously, the MAPP enrollment criteria were being interpreted very differently, which might have led to differing levels of enrollment and different demographic characteristics among program participants enrolled by these counties. Most survey respondents indicated a lack of knowledge regarding MAPP, and some respondents also pointed out that their county workers have a less than thorough understanding of the program.

Many participants reported that they did not know that they were enrolled in MAPP, and were therefore unaware of its benefit structure, employment requirement and available resources. It was hypothesized that the lack of knowledge was often a result of county workers switching participants from regular Medicaid to MAPP without notifying them of the change.²⁶ This finding was especially common for MAPP participants with previous Medicaid experience.

Because the health benefit packages for MAPP and regular Medicaid were identical, there might have been seemingly little reason for the county worker to inform the participant of the change to MAPP, thought this further suggested a lack of program understanding on the part of county workers. This may also support the theory that some county workers used MAPP, despite its employment requirement, to qualify people for Medicaid who had lost previous coverage and would not otherwise qualify by noting that they do some type of in-kind work. That so many survey respondents were unaware of the work requirement raised questions about whether the program was serving the original target population.²⁷ With few survey respondents aware of the work requirement, it is doubtful that a large number of program participants were engaged in substantial work activities. This finding was supported by the large number of zero and very low wage earners found in MAPP.²⁸

In 2007, 70% of MAPP survey respondents indicated they had one or more jobs, with the majority (66%) stating they had one job. Just under one-third of respondents (30%) said that they did not have a job.

About 86.5% of all respondents who indicated work indicated that they were paid money. They reported a mean hourly wage ranging from \$5.87 to \$8.68 per hour. Extrapolating this to a 40-hour work week and 52 week work year, on the higher end the average is just

²⁴ Not all counties were checked for this analysis; however, the counties identified above have the largest differences in percentage of \$0 wage earners relative their proportion of the entire MAPP population.

²⁵ High wage earners are those earning more than \$1,249 per month.

²⁶ An attempt was made to quantify the number of survey participants who did not recognize the MAPP program, and who did not know that they were enrolled in such a program by adding two additional questions to both surveys. However, there was not enough time prior to final data collection to collect the requisite number of responses needed to conduct a valid analysis.

²⁷ The original target population for MAPP was any disabled person who was, or could have been, engaged in “substantial” work.

²⁸ To further address the issue of the original MAPP target population, several survey findings in the Recipient Survey Report were analyzed relative to earned income reported in CARES.

over \$18,000 annually. The other 13.5% indicated they received some other type of compensation for their work, including rent, food or other valuables.

Evaluators undertook a cohort comparison in 2005 to pinpoint possible factors that resulted in a downward shift in earnings levels and premium payments over the first five years. This trend in earnings, and subsequently reduced contributions towards premiums, was the opposite of what was expected by the MAPP program. Slight changes in demographic composition of the program were also identified. It was hoped that by comparing the premium payments and earnings levels from different cohort groups, it would be determined whether these shifts were the result of changes in the behavior of MAPP participants or differences in the characteristics of consumers enrolled at different periods in time.

The first cohort of original enrollees comprised consumers who entered the MAPP program during the first few months of implementation (n = 2,109; March 2000—December 2001). As was reported in Years 1 and 2, the program was not well known; though training had occurred, county workers often misunderstood the program and the enrollment process was completed on paper.

The second cohort of post-automation enrollees comprised consumers who entered the MAPP program during the period immediately following automation of the enrollment process, such that MAPP became a routine consideration when a consumer applied for Medicaid (n=2,109; January 2002—September 2002). While transition to the automated application system made MAPP a much better known option and enrollment increased substantially, there are indications that county workers and enrollees still did not understand MAPP or grasp the enhanced opportunities to work and save as a MAPP participant.²⁹

The third cohort of late 2004 enrollees comprised the most recent group of consumers for whom data were available to complete the analysis (n=1,634; July 2004—December 2004). This cohort was considered to be most reflective of the typical profile of enrollees at the time the analysis was done.

Demographics: The average age of MAPP participants had crept upward by almost 3% over five years. The number of enrollees over the age of 50 had gradually increased from 38.4% in the first group, to 46% in the second, to nearly 50 percent (49.5%) in the third group. This trend may have indicated that an increased number of people were enrolling in MAPP to pay for age related health expenses rather than having a desire to work. Then again, this cohort still included working age individuals (ages 50—64) so this finding might also have reflected a change in the overall economy that motivated people in this age group to return to work.

The percentage of African American participants increased more than four times (2.1% to 9.5%) from the original group to the late 2004 group. The percentage of first time

²⁹ See Medicaid Purchase Plan Evaluation Annual Reports 2002 and 2003. Innovative Resource Group.

enrollees who were male declined from 52.5% in the original group, to 49.2% in the late 2004 group.

A clear difference in the percentage of premium payers was found between cohorts. The percentage of premium payers decreased from 17.1% in the initial group to 9.1% in the late 2004 enrollee group. Over five years, the number of premium paying participants decreased by almost 50% from its original level. One explanation for this decline is the possibility that initially the program may have attracted high earners, but as the program matured MAPP was also seen as a viable option for low earners.

Determining if MAPP is cost effective

Generally, there are two main types of measurable outcomes—those related to program participants (e.g., employment outcomes such as wage amount) and outcomes related to the program itself (e.g., cost effectiveness of program). Although outcome measurement primarily focused on outcomes related to program participants, program-level outcome analyses were also undertaken, mostly in the form of fiscal analyses.

MAPP was intended to be a cost effective, budget neutral program that did not impose any additional financial burden on Wisconsin's Medicaid program. Its premium structure was intended to help offset program costs by serving as a built-in cost-sharing mechanism—but with fewer and fewer program participants paying a premium over the years, this revenue source was threatened.

Beginning in October 2003, the Wisconsin Division of Health Care Financing (DHCF) began considering modifications to the premium formula to further offset program costs.

The evaluation team examined the budget impact of premium modification by compiling estimates that considered the impact of several changes to both the basic program eligibility requirements, as well as changes to the existing premium structure. These considerations included

1. Requiring evidence of any Federal Insurance Contribution's Act (FICA) contributions, such as wage stubs or self-employment tax forms in order to qualify for MAPP
2. Requiring evidence of a minimum monthly FICA contribution of \$296.67³⁰, as opposed to ANY FICA as in item one
3. Implementing a \$25 minimum premium for all program participants
4. Implementing a \$25 minimum premium for all program participants with individual income above 150% of FPL for their family size

³⁰ \$296.67/month was the equivalent of \$890 per quarter, which represents the Social Security Administration's (SSA) definition of a qualifying quarter for Social Security Disability Insurance (SSDI) in 2004.

5. Combining items one and three, resulting in any FICA contributions with all program participants paying a minimum \$25 premium
6. Combining items one and four, resulting in any FICA contributions with only those program participants with income above 150% FPL paying at least a minimum \$25 premium
7. Combining items two and three, resulting in FICA contributions above \$296.67 with all program participants paying a minimum \$25 premium
8. Combining items two and four, resulting in FICA contributions above \$296.67 with only those program participants with income above 150% FPL paying at least a minimum \$25 premium
9. Removing the \$25 dollar rate bands used to calculate the final premium amounts. Removing the rate bands would have resulted in participants paying the exact amount of their premium calculation, as opposed to rounding down to the nearest \$25 increment.

A major concern raised during discussions of the proposed MAPP eligibility and premium changes was the impact on enrollment of introducing a FICA requirement to the program. MAPP is a work incentive program where many program participants find employment that either pays very little, is sporadic, or is paid in-kind. Based on the data, very little of this income was formally reported, which limited the participant's ability to show evidence of FICA contributions. As a result, it was feared that a significant number of MAPP participants would be ineligible for the program. Any proposed FICA change might have significantly reduced the number of people served by Wisconsin MAPP, yet only have reduced overall Medicaid expenditures slightly or possibly remain at their current levels due to re-entry through other means.

Originally, it was estimated that 94% of MAPP participants would leave the program subsequent to eligibility and premium changes. This estimate was later revised to 86%, considering that some participants would re-enroll in some other Medicaid eligibility category. The final estimate showed that the greatest positive effect on the overall Medicaid budget would have resulted from implementing the \$25 minimum monthly premium for all participants who currently did not pay a premium, while maintaining the existing premium formula for those participants over 150% of FPL. This change was predicted to save Wisconsin Medicaid approximately \$2M annually, while having the smallest impact on MAPP enrollment and the accompanying MIG funding eligibility.

The \$25 minimum premium policy required a statutory change while the FICA changes did not; however, neither recommendation was ever implemented. As of 2011, no FICA requirement and no minimum premium of \$25 (or any other amount) had been implemented. This analysis was conducted in 2003—it is worth noting that the proportion of \$0 premium payers (i.e., those not paying a premium) continued to increase each year afterward. Had it been possible to predict that nearly 95% of MAPP participants would pay no premium in future years, perhaps efforts to implement a \$25, or even \$10, monthly premium might have gained more traction.

Although much of the discussion surrounding budget neutrality involves the notion of premium payments, it is important to note that even without premiums, enrollment data support the hypothesis that MAPP is a budget neutral program. Enrollment data consistently show that a majority of MAPP participants—nearly 90%—move between regular Medicaid and MAPP at some point(s). Given that this large majority of participants will likely receive MA one way or another, their participation in MAPP does not ultimately place an additional, overwhelming financial burden on the State.

Determining the fiscal impact of MAPP on other Medicaid and long-term care spending

The first major fiscal analysis was done three years into the life of MAPP, at which point a great amount of data was available for a more in-depth look at expenditures over the first three years of the program. The first fiscal analysis focused on describing the effect of MAPP program participation on Medicaid spending for health care services over the first three years of program implementation. The analysis examined differences in utilization and healthcare expenditures between MAPP participants who earn higher incomes and those with low, or no income. A follow up cost and utilization analysis was conducted in 2007.

The MAPP high-wage group tended to have slightly lower spending than the comparison group on most categories of service, although not significantly lower. The low-wage MAPP participants have significantly lower home health care spending, and slightly higher spending on drugs, professional services, and other non-institutional services not elsewhere classified. Otherwise, there is little distinction between MAPP participants' pattern of health care expenditures and those of comparable disabled Medicaid recipients not enrolled in MAPP. Whether or not one was eligible for Medicare or had prior experience with Medicaid seemed to have a much greater influence on Medicaid spending per person per month than did MAPP program participation.

With the introduction of Medicare Part D, which resulted in most prescription drug payments being diverted to Medicare instead of Medicaid, a follow up analysis was due. Four years after initially being studied, the issue of cost effectiveness was revisited.

The 2007 cost utilization and expenditure analysis compared the service usage and cost of MAPP participants to a comparable group enrolled in regular Medicaid.

The Medicaid expenditure and utilization by MAPP participants was compared to those of a group matched on several variables. The comparison group comprised Medicaid enrollees who were matched to the MAPP group on age, gender, Medicare participation, geographic area, and Medicaid eligibility status group. Compared to this group, the MAPP participants had \$50—\$100 lower over-all average expenditures per member per month (PMPM).

Similar overall patterns of expenditure were found. Looking at Figure 10 below, for both MAPP participants and a similar group of Medicaid enrollees, total spending rose by about \$300 per person per month between 2000 and 2005 (nominal dollars, not adjusted for inflation), and dropped by about \$300 per person per month from 2005 to 2006, when

Medicare Part D prescription drug coverage was implemented. Managed care capitation payments began rising faster after 2005 when Wisconsin implemented managed care for adults with disabilities.

Figure 17

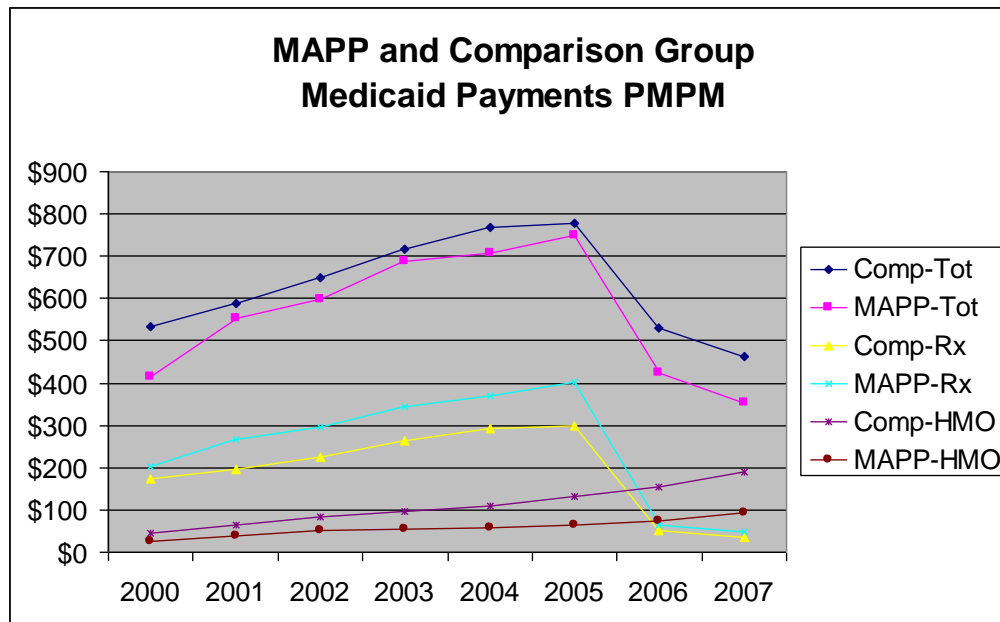


Table 3 below breaks out expenditures per person per month by calendar year and category of service.

Table 3

MAPP Expenditures Per Person/Per Month by Calendar Year and Category of Service								
	2000	2001	2002	2003	2004	2005	2006	2007
Drug	\$202	\$266	\$297	\$344	\$370	\$403	\$63	\$48
Physician	\$90	\$99	\$97	\$106	\$106	\$107	\$108	\$80
Inpatient	\$38	\$61	\$50	\$75	\$65	\$61	\$67	\$46
HH, etc.*	\$34	\$57	\$62	\$65	\$74	\$76	\$79	\$61
HMO Capitation	\$25	\$40	\$51	\$55	\$57	\$63	\$73	\$92
Other**	\$25	\$31	\$42	\$41	\$36	\$38	\$36	\$28
Total PMPM	\$415	\$554	\$599	\$686	\$708	\$749	\$426	\$355
*Home Health, DME, Transportation, Vision, Therapy, Misc.								
**Outpatient, Dental								

In addition to comparing the expenditures of MAPP participants with a comparison group, subgroup analyses within just the MAPP group were also conducted. Results of these analyses showed that differences in expenditures were found within the MAPP population across age, time of first enrollment, dual eligibility, and geographic location.

Participants eligible for Medicaid-only might have spent \$500—\$1,000 more PMPM. As expected, dually eligible enrollees had a large drop in PMPM in 2006 due to Part D drug

coverage, which did not affect the Medicaid-only enrollees. Utilization may have been about the same for the groups, but claims paid by Medicare were not included in the Medicaid paid claim database, which explains why the dual-eligible PMPM appeared to be lower.

The youngest (age 20—39) and oldest (age 70+) MAPP enrollees had the lowest expenditures PMPM. The younger enrollees may be in better general health, while the older enrollees have a higher mix of Medicare eligibility.

Comparing different cohorts of MAPP enrollees, it appeared that cohorts in more recent years have higher average spending than earlier cohorts who enrolled in 2000 through 2003. This corroborated a similar finding found from the cohort analysis completed two years prior.

MAPP participants who resided in urban or suburban areas incurred healthcare costs that were approximately \$100 more PMPM compared with residents in small towns or sparse rural areas. Exploring this issue, it was found that urban residents had higher HMO capitation payments PMPM (\$99 urban, \$19 rural), higher home health, etc. (\$88 urban, \$60 rural), and higher physician payments (\$110 urban, \$100 rural), which accounted for the difference in total expenditures PMPM.

It was unclear whether this difference was due to a difference in total utilization of services, perhaps due to less readily available access to health care in rural areas, or because of differences in pricing for services, or a different mix of services.

There were no major differences in MAPP expenditures PMPM in counties that began enrolling SSI adults with disabilities into managed care in 2005 (Milwaukee, Racine, Kenosha, and Waukesha) compared with the remaining counties where only FFS Medicaid was available for adults with disabilities.

Assessing the value of program participation for higher earning participants

MAPP was designed as a specialized Medicaid program that highlighted health care insurance and work incentive aspects. It was expected to attract people with disabilities who were already employed, as well as those individuals who wanted to return to work. Throughout MAPP's lifespan, there have been some challenges that impact higher earners more than lower or zero earners.

At one point a "MAPP Plus" initiative was explored. The main goal of MAPP Plus was to increase access to health care insurance to employees with disabilities by removing the income limits and asset tests currently in place for MAPP. There were a number of possibilities for designing a program to achieve the goals of MAPP Plus, and each option had pros and cons in terms of costs, administrative feasibility, state and federal approval, and appeal to employees with disabilities and their employers:

1. Individual coverage would be available to individuals engaged in full-time employment who are currently eligible for MAPP

2. The income and asset tests would be removed
3. Market-rate premiums that would achieve budget neutrality for the program and allow individuals or employers to pay the premium would be established

The ability to make MAPP Plus cost neutral through premiums was identified as one of the most significant barriers to the creation of a MAPP Plus program. The number of individuals who would be eligible for MAPP Plus and would choose to enroll in the program was expected to be relatively small. In June 2004, only 471 (representing 279 households) of the 6,667 MAPP enrollees had income above 200% of the FPL. The average annual Medicaid expenditure for these individuals was approximately \$7,200 from April 2003 through March 2004. Less than one-third had above average costs and would be likely to pay a premium based on average benefit cost plus administrative costs. Some of these individuals would have needed to increase their earnings by as much as 25% before they would be ineligible for MAPP. Therefore, it was expected that only a small subset of the 471 individuals would choose to graduate into MAPP Plus. It was expected that due to the small number of program participants, many with significant health care needs, it would be difficult to predict health care utilization and associated costs. For example, a single high-cost health care service (e.g., major surgery with complications) could easily push program costs beyond premium revenues.

Establishing premiums at a level intended to cover total program expenditures for individuals with significant health care needs would be similar to creating a high-risk health insurance pool. Such a program would be vulnerable to many of the challenges faced by these pools across the country such as adverse selection, which is, attracting a disproportionately large number of individuals who expect to have health care expenditures in excess of the premiums. Over time, this could result in a situation where program participation is limited to individuals with very high costs, which would exacerbate the situation and lead to the so called “death spiral” experienced by the Wisconsin Health Insurance Risk Sharing Pool (HIRSP) in the 1990s. During that period, HIRSP enrollment was declining while program costs were increasing leading to quickly rising premiums that led to further declines in enrollment. The individuals who remained on the plan had relatively high costs, which led to higher premiums, which in turn led to further reductions in enrollment. The end result was a severe financial crisis during which the plan became insolvent and claims went unpaid for four months. To keep the plan afloat, an additional \$2 million was collected from insurers through an emergency assessment.³¹

Even with sufficient data and the expertise of actuaries, it was nearly impossible to predict accurately the total health care expenditures of any size group. As a result, the

³¹ In order to maintain the long-term viability of HIRSP, a significant restructuring of the plan’s funding mechanism was undertaken in the late 1990s, and subsequently state general purpose revenue (GPR) was appropriated to help fund the plan. In 2002-03, after deducting the \$9.5 million GPR subsidy from total plan costs, 60% of the plan costs were funded through premium revenues. The remaining costs were covered through insurer assessments and provider contributions. Premium and deductible subsidies are also funded by insurer assessments and provider contributions.

only option for creating a program that is truly budget neutral was to recover the difference between premium revenues and program expenditures for a given year through increased premiums in the following year. Such a policy would likely have accelerated the adverse selection problem as individuals would be paying more than 100% of the average expected cost.

This MAPP Plus option was not expected to result in additional benefit costs to the State as eligible individuals would have already been receiving Medicaid benefits³² and likely would have maintained their Medicaid eligibility in the absence of this program. To help control benefit costs, under this alternative the Health Insurance Premium Payment Plan (HIPP) would be mandatory for MAPP Plus participants. Additionally, all MAPP Plus participants would be required to pay a premium to participate in the program.

The current asset test of \$15,000 would be maintained to limit the opportunity for individuals with high assets and low income to divest for six months as a means of obtaining Medicaid eligibility. In addition, Independence Accounts available under MAPP would be available under MAPP Plus. MAPP participants can deposit up to 50% of their annual earnings in registered independence accounts. These deposits are then exempt from the \$15,000 asset test.

With measures to offset benefit costs, it appeared that MAPP Plus was a cost effective and administratively feasible mechanism for increasing access to health care insurance for employees with disabilities while removing income limits. The “graduation” of current Medicaid-eligible individuals to MAPP plus and the new HIPP requirement was predicted to further allay Medicaid costs as a result of higher premium revenue and more employer-sponsored coverage for those eligible for Medicaid.

Retirement

Although MAPP Plus failed to gain traction, the issue of retirement still presented a significant problem to MAPP participants planning on retiring. Although MAPP permits and encourages earning and saving more, once a participant retires he or she is no longer eligible for MAPP. They may, however, be eligible for other medical assistance, but would likely be subject to traditional Medicaid income and asset rules. Suddenly, the savings that had been carefully accumulated might be subject to asset limits and spend-down rules effectively depleting the former MAPP participant of his or her retirement savings in order to retain health care coverage.

This challenge is perhaps one of the most complex and most demanding of a solution. It involves a shaky premise that threatens the foundation MAPP: If people with disabilities are encouraged to join MAPP so they can work and save for their future only to have

³² The group acknowledged that it would be possible for an individual who currently exceeds the Medicaid income limit to intentionally lower their income for six months in order to qualify for Medicaid and subsequently graduate into MAPP Plus. However, this was not expected to occur in many situations because these individuals have likely found alternative means for meeting their health care needs in the absence of MAPP Plus.

their savings decimated upon retirement, what was the point of all that work? For higher earners, the potential futility of MAPP is a serious issue, one that becomes more imperative to solve the closer the first generation of MAPP participants get to nearing retirement. That higher earners were specifically targeted for MAPP enrollment underscores the urgency of this issue even further.

The Office of Independence and Employment (OIE) explored the possibility of providing an additional MAPP eligibility category for MAPP enrollees who retire to neutralize the financial impact of retirement. The category, tentatively called MAPP Retirement (MAPP-R), was intended for individuals who worked while participating in MAPP or any other long-term support benefit and earned at or above the SGA limit for 24 consecutive months. After this 24-month period, their savings would vest and would no longer be subject to asset tests. This vesting option would help protect the savings of MAPP enrollees upon retirement.

A data analysis was conducted to determine how many MAPP participants would meet the two key eligibility requirements of the proposed MAPP-R category. Data from CARES suggested that around 40 individuals were earning at or above SGA (\$860/month) in December 2006. Of these individuals, 33 were also earning at or above SGA (\$830/month) one year before, in December 2005.

This simple calculation had a few caveats. For example, this calculation provided the number of MAPP participants meeting the SGA requirement at two points in time, one year apart. It did not provide counts of those participants meeting this requirement every month that year, nor did it provide a count of those participants who met this requirement for 24 consecutive months, as required by the proposed MAPP-R eligibility rule.

This brief analysis showed that relatively few MAPP participants would be immediate candidates for the new MAPP-R category. In addition to helping MAPP participants with significant savings to retire and retain health care coverage, the creation of MAPP-R might also have attracted additional higher earning participants to the program because of this assurance.

As of 2011, MAPP-R has also failed to gain sufficient Department support, leaving many MAPP participants who hope to retire in a detrimental catch-22 situation where they may have to continue working to remain eligible for MAPP, or retire and expose accumulated savings to the more stringent asset rules of regular Medicaid.

Goal: Allow people with disabilities to save and make purchases toward their independence, similar to opportunities currently available to the majority of the workforce.

Challenge identified:

- Were MAPP participants able to save money?

The main objective of this goal is to enable people with disabilities to have the same opportunities to save money, as well as to spend it, as the rest of the workforce. In addition to income and asset limits that are less restrictive than those of regular Medicaid, MAPP also permits its participants to save money in Independence Account—savings accounts that are protected from asset limits and are intended to allow participants to save and spend money toward independence-related purchases. Although touted as one of MAPP’s main goals, the ability to save has historically been quite limited.

In the 2002 survey, most MAPP participants reported that they did not have the available resources to begin saving at a significant level. Most respondents had saved nothing in the six months prior to the survey. This might have been less a reflection on the program and more an indication of the socioeconomic status of the MAPP participants. MAPP participants were generally very low income with significant health and long-term care needs, and many were on fixed incomes with little income from outside sources. These circumstances leave little opportunity to save. On average, initial respondents were able to save \$159³³ during the previous six months. Six-month respondents were able to save significantly more (\$339) in the six months prior to completion of the survey, implying that MAPP did help those who can afford to save actually save more. Twelve- and twenty-four month respondents were also able to save more. There was very little opportunity to save among MAPP participants, yet the program appeared to be meeting its goal of assisting those who can save, to save more.

In early 2010, income and Independence Account data from CARES was analyzed to learn more about how MAPP participants save. This brief analysis looked at a one-month snapshot of Independence Account data from December 2009. A more recent analysis on Independents Accounts was reported in Section III. The results of both analyses were very similar.

The following was noted:

- Eighty (0.5%) MAPP enrollees had one or more Independence Accounts, with 98 total accounts
- The range of balance amounts was \$1 to \$14,101
- The average account balance was \$3,096 and the median \$1,722.

That only half a percent of participants had any amount of savings in an Independence Account suggested that opportunities to save are limited and also perhaps that more could have been done by the state and county ES workers to inform participants of the program work incentive and savings opportunities. Looking to the income data recorded in CARES, a fuller picture emerged.

In December 2009, MAPP participants had gross earned income ranging from \$0 to \$5,395 per month, with an average of \$146 per month and median of \$21 per month.

³³ The savings figures represent anyone who responded to the question, “How much did you save in the last 6 months?” and therefore includes many respondents who indicated that they saved \$0.

These figures represent a continued decline from previous years; in December 2008, the average gross earned income was \$167 per month with a median of \$27 per month.

In December 2009, of the 15,990 individuals for whom earned income data were available, 1.4% (236) were earning at or above SGA³⁴, with the remainder falling below, most far below. This percentage has decreased each year, from 1.9% in 2008 and 2.6% in 2007. About 72% of MAPP participants had an earned income of \$100 or less, up slightly from 68% in 2008, and 65% in 2007. This demonstrates the trend toward lower earned income.

Although several possible factors might be responsible for the increasing prevalence of low and zero earnings, it is clear that the majority of MAPP participants likely do not have a surplus of earned income to deposit into a savings account. This brief analysis did not take into account unearned income, of which most MAPP participants are beneficiaries, but it is unlikely that those depending solely on their SSDI cash benefit for income would have a surplus for saving.

³⁴ \$980/month in 2009. SGA is used as the threshold to separate people as several benefit rules are tied to it, MAPP eligibility *not* being one such benefit.

V. Summary

MAPP was designed to support the health care coverage needs of people with disabilities who work. As summarized in this report, one could say that MAPP has met its three program goals with limited success. It is a program that requires employment in exchange for health care coverage, yet it appears that as the program has evolved over the years, this requirement may have become diluted.

The reasons for this evolution are complex and uncertain. In addition to internal, programmatic issues, there are also external issues tied to other disability benefits, such as SSDI. For example, the fear of losing one's health care benefit is clearly a disincentive to working and earning more, in an effort to avoid surpassing SGA and jeopardizing the cash benefit. The complexities of how benefits interact may be difficult to navigate, and the fear of losing one's cash benefits or health care—arguably the two most important benefits for a person with a disability—may encourage limited participation in the workforce.

Ultimately, MAPP provides an important benefit for many Wisconsin residents who are disabled and working, in that it allows them to receive health care coverage while they work and to save above traditional Medicaid income and asset limits. Until a smooth transition to retirement can be assured, however, the issue of retirement may remain as yet another disincentive to working and earning more.

VI. Appendix

Attachment A – Premium Schedule

PREMIUM SCHEDULE					
Sum of Adjusted Countable Unearned and Adjusted Earned Income		The Premium is:	Sum of Adjusted countable Unearned and Adjusted Earned Income		The Premium is:
From	To	Premium	From	To	Premium
\$0	\$10.00	\$0.00	500.01	525.00	500.00
10.01	25.00	\$0.00	525.01	550.00	525.00
25.01	50.00	25.00	550.01	575.01	550.00
50.01	75.00	50.00	575.01	600.00	575.00
75.01	100.00	75.00	600.01	625.00	600.00
100.01	125.00	100.00	625.01	650.00	625.00
125.01	150.00	125.00	650.01	675.00	650.00
150.01	175.00	150.00	675.01	700.00	675.00
175.01	200.00	175.00	700.01	725.00	700.00
200.01	225.00	200.00	725.01	750.00	725.00
225.01	250.00	225.00	750.01	775.00	750.00
250.01	275.00	250.00	775.01	800.00	775.00
275.01	300.00	275.00	800.01	825.00	800.00
300.01	325.00	300.00	825.01	850.00	825.00
325.01	350.00	325.00	850.01	875.00	850.00
350.01	375.00	350.00	875.01	900.00	875.00
375.01	400.00	375.00	900.01	925.00	900.00
400.01	425.00	400.00	925.01	950.00	925.00
450.01	475.00	450.00	9950.01	975.00	950.00
475.01	500.00	475.00	975.01	1,000.00	975.00

Note: If the sum of Adjusted Countable Unearned Income and Adjusted Earned Income is greater than \$1,000.00 per month, the premium is equal to the exact dollar amount of this sum.

Attachment B – Eligibility Trends for MAPP Participants

Month/ Year	New MAPP Enrollees	# With Elig. Prior Month	% With Elig. Prior Month	# With Any Prior Elig.	% With Any Prior Elig.	# With Post MAPP Elig.	# MAPP Disenroll	# MAPP Net Enroll
Jan-00	32	7	21.9%	24	75.0%	31	0	32
Feb-00	14	5	35.7%	10	71.4%	14	1	13
Mar-00	39	18	46.2%	33	84.6%	37	0	39
Apr-00	40	17	42.5%	34	85.0%	37	0	40
May-00	61	32	52.5%	52	85.2%	54	2	59
Jun-00	113	67	59.3%	95	84.1%	109	1	112
Jul-00	129	77	59.7%	113	87.6%	119	2	127
Aug-00	106	58	54.7%	92	86.8%	103	3	103
Sep-00	101	51	50.5%	88	87.1%	98	7	94
Oct-00	124	70	56.5%	108	87.1%	117	7	117
Nov-00	116	76	65.5%	97	83.6%	107	5	111
Dec-00	131	106	80.9%	120	91.6%	120	11	120
Jan-01	158	86	54.4%	134	84.8%	146	7	151
Feb-01	95	58	61.1%	81	85.3%	85	5	90
Mar-01	100	62	62.0%	87	87.0%	90	10	90
Apr-01	75	45	60.0%	66	88.0%	70	16	59
May-01	84	54	64.3%	77	91.7%	77	17	67
Jun-01	78	49	62.8%	62	79.5%	74	17	61
Jul-01	82	56	68.3%	73	89.0%	76	11	71
Aug-01	76	43	56.6%	66	86.8%	70	8	68
Sep-01	93	57	61.3%	81	87.1%	85	16	77
Oct-01	80	43	53.8%	68	85.0%	72	22	58
Nov-01	94	55	58.5%	82	87.2%	81	16	78
Dec-01	80	46	57.5%	65	81.3%	72	14	66
Jan-02	185	114	61.6%	158	85.4%	169	22	163
Feb-02	294	225	76.5%	265	90.1%	269	16	278
Mar-02	241	156	64.7%	212	88.0%	220	28	213
Apr-02	230	148	64.3%	195	84.8%	196	24	206
May-02	243	152	62.6%	206	84.8%	211	37	206
Jun-02	235	148	63.0%	206	87.7%	210	37	198
Jul-02	264	173	65.5%	221	83.7%	223	40	224
Aug-02	207	126	60.9%	174	84.1%	177	36	171
Sep-02	211	135	64.0%	185	87.7%	188	34	177
Oct-02	233	143	61.4%	201	86.3%	199	37	196
Nov-02	196	123	62.8%	172	87.8%	183	45	151
Dec-02	200	134	67.0%	176	88.0%	158	44	156
Jan-03	285	187	65.6%	255	89.5%	228	62	223
Feb-03	212	133	62.7%	184	86.8%	170	51	161
Mar-03	241	161	66.8%	206	85.5%	196	51	190
Apr-03	219	137	62.6%	194	88.6%	173	56	163
May-03	201	126	62.7%	174	86.6%	146	38	163
Jun-03	222	144	64.9%	196	88.3%	173	50	172
Jul-03	236	140	59.3%	201	85.2%	190	47	189
Aug-03	229	144	62.9%	198	86.5%	192	77	152
Sep-03	247	142	57.5%	211	85.4%	194	60	187
Oct-03	223	143	64.1%	188	84.3%	177	63	160
Nov-03	241	136	56.4%	199	82.6%	187	54	187

Month/ Year	New MAPP Enrollees	# With Elig. Prior Month	% With Elig. Prior Month	# With Any Prior Elig.	% With Any Prior Elig.	# With Post MAPP Elig.	# MAPP Disenroll	# MAPP Net Enroll
Dec-03	220	133	60.5%	185	84.1%	179	84	136
Jan-04	284	193	68.0%	263	92.6%	223	71	213
Feb-04	307	204	66.4%	269	87.6%	246	77	230
Mar-04	226	134	59.3%	192	85.0%	177	67	159
Apr-04	270	177	65.6%	242	89.6%	196	63	207
May-04	283	199	70.3%	252	89.0%	230	61	222
Jun-04	253	168	66.4%	216	85.4%	200	72	181
Jul-04	262	184	70.2%	238	90.8%	221	73	189
Aug-04	266	174	65.4%	226	85.0%	213	76	190
Sep-04	254	159	62.6%	230	90.6%	196	74	180
Oct-04	269	170	63.2%	236	87.7%	215	79	190
Nov-04	260	162	62.3%	223	85.8%	190	95	165
Dec-04	330	251	76.1%	302	91.5%	268	91	239
Jan-05	354	240	67.8%	321	90.7%	273	89	265
Feb-05	279	186	66.7%	253	90.7%	228	101	178
Mar-05	283	181	64.0%	250	88.3%	219	97	186
Apr-05	287	191	66.6%	252	87.8%	230	119	168
May-05	284	184	64.8%	244	85.9%	226	113	171
Jun-05	319	219	68.7%	286	89.7%	241	101	218
Jul-05	275	184	66.9%	239	86.9%	215	98	177
Aug-05	302	190	62.9%	267	88.4%	226	125	177
Sep-05	293	184	62.8%	254	86.7%	215	98	195
Oct-05	289	185	64.0%	249	86.2%	214	138	151
Nov-05	256	165	64.5%	229	89.5%	197	139	117
Dec-05	274	184	67.2%	242	88.3%	204	146	128
Jan-06	335	209	62.4%	291	86.9%	257	105	230
Feb-06	240	162	67.5%	208	86.7%	186	124	116
Mar-06	278	178	64.0%	247	88.8%	219	150	128
Apr-06	236	139	58.9%	208	88.1%	174	110	126
May-06	241	149	61.8%	214	88.8%	199	132	109
Jun-06	256	169	66.0%	229	89.5%	195	125	131
Jul-06	245	152	62.0%	216	88.2%	193	145	100
Aug-06	257	155	60.3%	223	86.8%	199	145	112
Sep-06	270	169	62.6%	241	89.3%	210	132	138
Oct-06	249	156	62.7%	219	88.0%	194	133	116
Nov-06	219	139	63.5%	197	90.0%	175	132	87
Dec-06	258	157	60.9%	229	88.8%	200	178	80
Jan-07	336	202	60.1%	307	91.4%	262	123	213
Feb-07	284	182	64.1%	258	90.8%	221	142	142
Mar-07	261	166	63.6%	244	93.5%	204	160	101
Apr-07	226	131	58.0%	203	89.8%	180	135	91
May-07	235	135	57.4%	206	87.7%	182	148	87
Jun-07	256	138	53.9%	229	89.5%	195	111	145
Jul-07	261	150	57.5%	227	87.0%	201	161	100
Aug-07	289	158	54.7%	255	88.2%	208	161	128
Sep-07	271	158	58.3%	239	88.2%	211	139	132
Oct-07	281	165	58.7%	250	89.0%	205	155	126
Nov-07	249	136	54.6%	217	87.1%	189	138	111
Dec-07	264	172	65.2%	236	89.4%	196	148	116
Jan - 08	279	156	55.9%	245	87.8%	217	147	132
Feb - 08	279	186	66.7%	262	93.9%	213	169	110
Mar - 08	251	153	61.0%	222	88.4%	202	158	93

Month/ Year	New MAPP Enrollees	# With Elig. Prior Month	% With Elig. Prior Month	# With Any Prior Elig.	% With Any Prior Elig.	# With Post MAPP Elig.	# MAPP Disenroll	# MAPP Net Enroll
Apr - 08	282	143	50.7%	248	87.9%	213	180	102
May - 08	311	180	57.9%	280	90.0%	244	141	170
Jun - 08	288	156	54.2%	259	89.9%	218	188	100
Jul - 08	288	166	57.6%	262	91.0%	216	171	117
Aug - 08	278	143	51.4%	246	88.5%	208	199	79
Sep - 08	283	149	52.7%	251	88.7%	211	156	127
Oct - 08	316	177	56.0%	280	88.6%	238	155	161
Nov - 08	335	158	47.2%	296	88.4%	236	150	185
Dec - 08	303	131	43.2%	279	92.1%	212	190	113
Jan - 09	408	156	38.2%	366	89.7%	274	173	235
Feb - 09	274	85	31.0%	248	90.5%	188	197	77
Mar - 09	329	122	37.1%	284	86.3%	212	205	124
Apr -09	341	125	36.7%	310	90.9%	221	218	123
May - 09	308	118	38.3%	272	88.3%	198	198	110
Jun - 09	339	114	33.6%	304	89.7%	218	205	134
July 2009	324	127	39.2%	287	88.6%	192	223	101
Aug - 09	340	122	35.9%	295	86.8%	202	225	115
Sep - 09	367	116	31.6%	315	85.8%	200	225	142
Oct - 09	389	152	39.1%	336	86.4%	182	194	195
Nov -09	339	119	35.1%	292	86.1%	157	221	118
Dec - 09	357	136	38.1%	319	89.4%	172	242	115
Jan-10	408	128	31.4%	362	88.7%	288	181	227
Feb-10	355	124	34.9%	320	90.1%	251	204	151
Mar-10	429	159	37.1%	366	85.3%	276	203	226
Apr-10	383	112	29.2%	336	87.7%	266	203	180
May-10	379	148	39.1%	330	87.1%	237	258	121
Jun-10	371	149	40.2%	327	88.1%	240	217	154
Jul-10	410	178	43.4%	358	87.3%	267	206	204
Aug-10	381	133	34.9%	336	88.2%	229	281	100
Sep-10	406	145	35.7%	351	86.5%	225	243	163
Oct-10	415	170	41.0%	371	89.4%	239	265	150
Nov-10	381	123	32.3%	330	86.6%	222	267	114
Dec-10	370	145	39.2%	316	85.4%	178	261	109
Jan-11	439	144	32.8%	392	89.3%	203	263	176
Feb-11	392	148	37.8%	354	90.3%	197	288	104
Mar-11	415	142	34.2%	369	88.9%	182	262	153
Apr-11	365	114	31.2%	321	87.9%	157	277	88
May-11	340	139	40.9%	294	86.5%	145	329	11
Jun-11	415	136	32.8%	367	88.4%	156	334	81
Jul-11	369	163	44.2%	333	90.2%	122	320	49
Aug-11	348	122	35.1%	301	86.5%	113	376	-28
Sep-11	360	123	34.2%	316	87.8%	86	339	21
Sums	36,415	19,321	53.1%	32,050	88.0%	27,411	16,272	20,144

* Source: Eligibility trends spreadsheet

1 The minimum MAPP enrollment date for an individual

2 Individuals having a non-MAPP eligibility segment with an end date between the minimum MAPP start date and 31 days prior to the minimum MAPP start date

3 Individuals having a non-MAPP eligibility segment with an end date before the minimum MAPP start date

4 Individuals having a non-MAPP eligibility segment beginning after their minimum MAPP start date. The assigned month represents the first month of the non-MAPP eligibility segment.

5 The maximum MAPP end date for an individual (most recent disenrollment). Disenrollees include all MAPP enrollees that have not re-enrolled in MAPP as of the month of this report.

6 New MAPP enrollees minus MAPP disenrollees for each month

Attachment C – IRWE and MRWE examples

Examples of Impairment Related Work Expenses (IRWE):

- Attendant care services (at work, for transportation, other)
- Diagnostic procedures
- Durable medical equipment (plus installation, maintenance, and associated repair costs)
- Essential non-medical appliances and devices (electric air cleaner, etc.)
- Exterior home modifications that allow access to the street or to transportation (ramps, railings, pathways, etc.)
- Interior home modifications which create a work to accommodate impairment (enlargement of doorway, etc.)
- Interpreter (at workplace)
- Job coach
- Medical devices
- Measuring instruments
- Mileage allowance (to and from work)
- Modified audio/visual equipment (enlarged monitor, speech activated computer, etc.)
- Pacemakers
- Physical therapy
- Prostheses
- Reading aids
- Regularly prescribed medical treatment or therapy and physician's fees associated with this treatment
- Respirators
- Routine prescription drugs
- Special work tools
- Traction equipment, braces
- Typing aids
- Vehicle modification (plus installation, maintenance, and associated repair costs)
- Wheelchairs
- Work animal and associated costs (plus food, maintenance, and veterinary services)
- Workspace modifications (adjustable desk, etc.)
- Work subsidy (increased supervision, etc.)

Examples of Medical Remedial Expenses

- Abdominal supports; back supports
- Acupuncture
- Artificial teeth, eyes, limbs

- Attendant care (at workplace or other)
- Audio/visual equipment, such as screen magnifiers
- Automobile or van modification
- Automobile modified equipment; Autoette
- Bathtub/Shower accessibility modifications and related adaptive hardware
- Bed pads; bed boards
- Chiropractor
- Computer/desk modifications
- Convalescent home
- Diapers
- Dietician/Nutritionist services or information
- Elevator
- Eyeglass prescriptions
- Excess energy costs related to a medical condition
- Handrails
- Healing services
- Health institute fees
- Health spa
- Hearing aids
- Home improvements made for medical reasons: air conditioning system, bathroom on the first floor, ramps, doorway modifications, etc.
- Hydrotherapy
- Inclinator or other device for managing stairs
- Invalid chair
- Job coach
- Life-care fee (medical portion only)
- Lodging on trips to obtain medical care
- Medicaid co-payments
- Medical supplies
- Modified clothing
- Modified eating utensils
- Outstanding medical bills
- Practical/other nonprofessional nurse for med services
- Prescription drugs
- Private health insurance premiums
- Reclining chairs
- Registered nurse
- Rental of medical equipment
- Repair of special medical equipment
- Respite care
- Special mattresses
- Special plumbing fixtures
- Special telephone equipment and associated repair costs

- Special technology needs
- Transportation costs for medical visits
- Vitamin supplements
- Wheelchair; other equipment
- Wages of guide/assistant
- Whirlpool
- Work animals and associated maintenance costs (plus food, maintenance, and veterinary services)